CHRISTUS Trinity Mother Frances Health System

Community Health Needs Assessment 2020-2022

About Texas Health Institute:

Texas Health Institute (THI) is a non-profit, non-partisan public health institute. Since 1964, THI has served as a trusted, leading voice on public health and healthcare issues in Texas and the nation. THI's expertise, strategies, and nimble approach makes it an integral and essential partner in driving systems change efforts. THI works across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life.

Developed by:

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EXECUTIVE SUMMARY

CHRISTUS Trinity Mother Frances Health System is a non-profit, Catholic integrated health care delivery system that includes acute care hospitals in five counties in Upper East Texas. CHRISTUS Trinity Mother Frances Health System's dedicated staff provides specialty care tailored to the individual needs of every patient, aiming to deliver high-quality services with excellent clinical outcomes. CHRISTUS Trinity Mother Frances Health System works closely with the local community to ensure regional health needs are identified and incorporated into system-wide planning and strategy. To this end, CHRISTUS Trinity Mother Frances Health System commissioned Texas Health Institute to conduct and produce its 2020-2022 Community Health Needs Assessment (CHNA), as required by law to be performed once every three years as a condition of 501(c)(3) tax-exempt status.

In this community health needs assessment, THI staff and CHRISTUS Trinity Mother Frances Health System community stakeholders analyzed over 40 different indicators of health needs based on demographics and socioeconomic trends; measures of physical, behavioral, social, and emotional health; and risk factors and behaviors that promote health or produce sickness. The latter provided insight into social determinants of health operating in the report area, such as transportation, and food insecurity. Report findings combine secondary analysis from publicly available data sources, hospital utilization data and input from those with close knowledge of the local public health and health care systems to present a comprehensive overview of unmet health needs in the region.

The voice of the community guided the needs assessment process throughout the life of the project, ensuring the data and analyses remained grounded in local context. Focus group and needs prioritization meetings ensured input from low income and minority communities and stakeholders representing those communities. Through an iterative process of community debriefing and refinement of findings, a final list of five prioritized health concerns were developed. These are summarized in the table below. This priority list of health needs and the data compiled in support of their selection lays the foundation for CHRISTUS Trinity Mother Frances Health System to remain an active, informed partner in population health in the region for years to come.

Rank	Health Concern
1	Behavioral Health
2	High Emergency Department Use
3	Specialty Care and Chronic Illness
4	Primary Care and Elderly Needs
5	Education

CHRISTUS Trinity Mother Frances Health System Prioritized Health Needs, 2020-2022

INTRODUCTION

CHRISTUS Trinity Mother Frances Health System (CTMFHS) is a non-profit hospital system serving the Upper East Texas region. In addition to the 402-bed CHRISTUS Mother Frances Hospital and 51-bed Louis and Peaches Owen Heart Hospital in Tyler, Texas, CTMFHS includes acute hospitals and inpatient facilities in Jacksonville, South Tyler, Sulphur Springs, and Winnsboro. In addition, CTMFHS includes a long-term acute care hospital in Tyler; clinics and outpatient centers spread across Tyler, Jacksonville, Canton, Lindale, and Flint; physician partnerships, PHOs, and MSOs; several collaborative ventures and affiliations; and the CHRISTUS Trinity Mother Frances Foundation.[1]

While CTMFHS serves a wide swath of Upper East Texas, CTMFHS defines the report area for this Community Health Needs Assessment (CHNA) to include the following seven Texas counties: Delta, Franklin, Hopkins, Rains, Wood, Smith, and Cherokee. The demography and socioeconomic conditions of these counties are broadly representative of the CTMFHS service area. As such, they offer insight into the health needs of the patients of and communities surrounding the seven hospitals for which this CHNA is conducted. [2]

CHRISTUS Health is a Catholic health system formed in 1999 to strengthen the faith-based health care ministries of the Congregations of the Sisters of the Incarnate Word of Houston and San Antonio that began in 1866. In 2016, the Sisters of the Holy Family of Nazareth became the third sponsoring congregation to CHRISTUS Health. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. CHRISTUS Health facilities are also located in Louisiana, Arkansas, and New Mexico. It also has 12 international hospitals in Colombia, Mexico and Chile. As part of CHRISTUS Health's mission "to extend the healing ministry of Jesus Christ," CTMF strives to be, "a leader, a partner, and an advocate in the creation of innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God's healing presence and love."[3]

Federal law requires all non-profit hospitals to conduct a CHNA every three years to maintain their tax-exempt status. CHRISTUS Health contracted with Texas Health Institute (THI) to develop the CHNA report for CTMFHS, a document that will fulfill the requirements set forth in IRS Notice 2011-52, 990 requirements for non-profit hospitals' community health needs assessments and will be made available to the public. To complete its CHNA, the THI team and CTMFHS leadership drew upon a wide range of primary and secondary data sources and engaged a group of community residents and stakeholders with special knowledge of vulnerable population groups and the local public health landscape. All together, these data and diverse

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[1] CHRISTUS Health. (2018). *System Profile 2018*. Available at: https://www.christushealth.org/-/media/files/Homepage/About/2018_SysProfile.ashx.

[2] The following seven facilities are included in the CHNA for CTMFHS: CHRISTUS Mother Frances Jacksonville, CHRISTUS Mother Frances South Tyler, CHRISTUS Mother Frances Tyler, CHRISTUS Louis and Peaches Owen Heart Hospital, CHRISTUS Trinity Mother Frances Rehab Hospital, CHRISTUS Mother Frances Winnsboro, and CHRISTUS Mother Frances Hospital Sulphur Springs. Note that Tyler Continue Care Hospital at Mother Frances Hospital is not including in this CHNA.

[3] CHRISTUS Health. (2019). Our mission, values, and vision. Available at: http://www.christushealth.org/OurMission.

perspectives provide insight into community health needs, priorities, challenges, resources, and potential solutions.

A CHNA ensures that CTMFHS has made efforts to identify the unmet health needs of residents in its service region, examine barriers residents face in achieving and maintaining good health status and inventory health opportunities and assets available within the report area that can be leveraged toward the improvement of population health. The CHNA lays the foundation for future planning, ensuring that CTMFHS is prepared to undertake efforts that will help residents of the local community attain the highest possible standard of health.

METHODOLOGY

REVIEW OF LITERATURE AND QUANTITATIVE DATA

THI staff conducted a literature review using previously published community health needs assessments and other reports focused on health in report region. These included regional assessments such as the *Regional Needs Assessment* released in 2018 by the Prevention Resource Center 4 and the Health Assessment and *The Health Status of Northeast Texas* released by the University of Texas Health Science Center at Tyler.[4,5] Findings from the literature review, CTMFHS's prior CHNA, and CTMFHS progress reporting on initiatives launched in response were incorporated into project design, interviews, focus groups, and this report as applicable.

THI used a mixed-methods approach to data collection and analysis. Both qualitative and quantitative measures are drawn from primary and secondary data sources to ensure a comprehensive understanding of health needs and the potential for CTMFHS to address those needs in collaboration with community partners. This mixed-methods approach is standard in all THI needs assessments and was used in concurrent needs assessments in five other CHRISTUS services areas in 2019.

CHNA development began with collection and examination of quantitative data from secondary sources. Unless otherwise specified, all data were accessed from Community Commons, a repository of community-level data compiled from archival sources including, but not limited to, the American Community Survey, U.S. Census Bureau, the CDC Behavioral Risk Factor Surveillance System, and the National Vital Statistics System. The most recent data available from this source were examined for the report area in aggregate and by county across several dimensions, including sociodemographics, health risk behaviors, access to care and clinical outcomes. THI subsequently obtained internal data from CTMFHS's main and satellite hospitals and conducted a descriptive analysis. Together, THI staff reviewed over 40 measures and categorized them for higher-level examination.

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[4] Regional Needs Assessment. (2018). Region 4 Prevention Resource Center. Available at: https://www.etcada.com/rna.

[5] The Health of Northeast Texas 2016. UT Health Science Center at Tyler. Available at: https://utsystem.edu/sites/default/files/news/assets/northeasttx-health-status-report-2016.pdf

KEY INFORMANT INTERVIEWS

Purpose

The purpose of in-depth interviews was to gather a broad sample of perspectives on significant health needs in the community. Findings from interviews informed the design of the focus group and were incorporated into the results to lend context to quantitative patterns and trends. Semi-structured interviews followed a pre-designed questionnaire covering the identification of health needs, community resources, and possible opportunities for action. The interviewer asked about barriers and reasons for unmet health needs, existing capacity, needed resources, and potential solutions that could enhance well-being in the community, either for specific subgroups or the population at-large. The full-length Key Informant Interview Protocol can be found in Appendix B of this report.

Sample and Recruitment

Representatives from CTMFHS contributed contact information for 16 people who represent the broad interests of Tyler and who possess knowledge about the region's health-related challenges. For example, key stakeholders included nonprofit leaders, health department authorities, university and college leaders, healthcare providers or leaders, human services providers, local and state agencies, people representing distinct geographic areas and people representing diverse racial/ethnic groups.

To recruit interviewees the THI team contacted these 31 key informants by email and telephone, and 16 individuals responded to the request. THI conducted 16 interviews between September and December 2018, each lasting between 30 to 60 minutes.

Transcription

THI used the notes and recordings to develop transcripts of each key informant interview for later coding and analysis. The identities of key informants and transcribed content of their statements will remain confidential.

FOCUS GROUP

Purpose and Questions to Address

The purpose of the focus group was to obtain clarity around needs and concepts proposed for inclusion in the CHNA report, and to approximate a group response to the collection of ideas put forth. The group followed a semi-structured protocol intended to elicit responses aligned with the following objectives:

1. Identify significant health needs
2. Identify community resources to meet its health needs
3. Identify barriers and reasons for unmet health needs
4. Identify supports, programs, and services that would help to improve the needs or issues

THI staff finalized the design of the focus group guide after a review of quantitative data and discussions with CTMFHS staff.

Recruitment and Sample

Potential participants were identified by CTMFHS leadership. A total of 13 people participated in the Tyler/Jacksonville focus group and 13 people participated in the Sulphur Springs focus group. To assist with recruitment the local CHRISTUS liaison recruited these stakeholders who represented diverse population groups, occupations, and healthcare or related service providers (e.g., clinics, community organizations and social service agencies).

Administering Focus Group and Collecting Data

The focus group lasted two hours. The facilitator opened with a general assessment of the participants' views of the community's overall health profile, inviting general comments using open-ended questions about health needs. Next, the facilitator followed with probes regarding any health needs that arose in the quantitative and qualitative analyses but did not appear in the group members' initial responses. An assistant moderator took notes and recorded the group responses. THI used the notes and recordings to develop transcripts for later coding and analysis.

ANALYSIS

Quantitative Analysis

The first stage of the analysis involved comparing rates of mortality, morbidity, health utilization, and various measures of social determinants of health using publicly available secondary data sources. The THI team compared the rates in the report area with Texas and the US to determine evidence of "health needs."[6] These comparisons represented quantitative indicators of need. For example, if the lung cancer rate in the report area were greater than the rate in Texas, that would be indicative of the need for more oncological services or primary prevention (e.g., reducing cigarette smoking). In addition to these comparisons, THI compared rates across counties within the report area to uncover potential regional disparities.

Primary data from CTMFHS provided additional information to supplement the analysis of health needs. THI calculated rates of hospital and emergency room admissions. Indicators from these data were based on comparisons across facility, service line, payment type, and zip code. For example, if ER visits for an ambulatory care sensitive condition were concentrated in one zip code, along with increasing trends across adjacent years, this might be indicative of the need to improve access to primary care in that region.

Qualitative Analysis

Whereas quantitative data analysis provides evidence of the magnitude of various health needs in the report area population (relative to a standard), qualitative data analysis facilitates exploration of *why* those health needs were arising in the report area and *how* the community could potentially respond.

[6] Rates were age-adjusted for comparisons.

THI utilized a hybrid approach to qualitative analysis based on both thematic and content analysis as well as grounded theory-based methods.[7,8,9] Whereas thematic analysis identifies and *qualifies* narratives, content analysis identifies and *quantifies* recurring narratives.[10] These two approaches are used to develop a comprehensive understanding of the report area while identifying priority health needs based on the weight of the evidence.

Grounded theory is an inductive approach to forming an understanding of a phenomenon that best fits *all* the data. The approach is an iterative process that involves collecting the data, coding similar concepts, forming concepts into categories, generating theory, and then going back to the data to verify the theory. THI used this iterative process to identify recurring themes that evidenced community health needs and health system needs—instead of generating theory per se. The iterative nature of collecting, analyzing, and reviewing data with stakeholders was built into THI's CHNA process from start to finish.

From successive readings of key informant and focus group transcripts, the THI team methodologically analyzed transcripts to understand interviewee narratives. The analysis focused on understanding stakeholders and focus group participant views with respect to (1) health needs (including physical, behavioral, and social/emotional) (2) the social determinants of health (3) barriers to care and (4) assets and solutions to address population health and health system needs. Next, the THI team tagged transcript passages, open-coded key concepts within passages, compared patterns of codes within and across transcripts, and collapsed these codes into thematic categories.

The key informant interviews and focus group interviews varied in the themes that arose. In addition, some of the themes were supported by quantitative findings. The THI team therefore triangulated the results across all the data—key informant interviews, the focus group interview, and quantitative measures—to identify themes that emerged most frequently. These themes essentially offer a "theory" about the health needs in the community and the ways in which (health and non-health sector) systems could improve to support greater health outcomes in the report area. The last stage of the analysis involved verifying whether these themes were an accurate reflection of health and systems needs in the service area. This last step was incorporated as part of the needs prioritization.

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[7] Smith, J., & Firth, J. (2011). Qualitative data analysis: the framework approach. *Nurse researcher*, *18*(2), 52-62.
[8] Joffe, H., & Yardley, L. (2004). Content and thematic analysis. *Research methods for clinical and health psychology*, *56*, 68.
[9] Corbin, J. & Strauss, A. (1990). Grounded theory method: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13, 3-21.
[10] Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences*, *15*(3), 398-405.

NEEDS PRIORITIZATION

Phase 1: Initial Prioritization

The needs prioritization occurred in two phases. The first phase included a data-based prioritization from the THI team in advance of convening a needs prioritization committee comprised of local stakeholders. In this phase, THI identified the top indicators of need based on both the qualitative and quantitative analysis. The top indicators based on the qualitative analysis included the most recurring themes for which there was the greatest evidence base on all available data. These emerged in the process of triangulation described above.

For quantitative analysis, THI determined whether:

- Rates for the report area exceeded those for Texas or the US.
- Health measures were deemed to impact a large percentage of residents in the report area.
- Evidence of significant variation in rates across counties in the report area, indicating potential regional disparities.

This process enabled THI to sort quantitative indicators across three tiers—those with (I) clear, (II) middling, or (III) no evidence of health needs. All of Tier I and some of Tier II indicators were assembled for presentation at a needs prioritization workshop.

Phase 2: Workshop for Validation and Prioritization

The second phase involved facilitating a community-driven process to validate phase 1 findings and further refine and prioritize health needs. More specifically, the key objectives of this process were to determine the validity of THI's findings about community health needs (i.e., phase 1 results), identify a core set of community health issue areas for more focused discussion, and implement a fair process that enabled the group to prioritize needs through generative dialogue and group consensus.

To do this, THI designed a needs prioritization workshop that combined focused discussion with liberating structures.[11] The workshop design (1) facilitated a fair and inclusive process so that all the stakeholders could review and comment on preliminary results on an equal footing, (2) enabled all stakeholders to feel free to present their views about the core health needs in the community, and (3) utilized a cumulative voting method to prioritize needs after uncovering the diverse perspectives of the group.

The needs prioritization workshop took place in January 2019. THI staff informed the CTMFHS liaison about the purpose of this meeting and appropriate logistics were arranged. The local liaison recruited individuals from the community to serve on the needs prioritization committee, and 28 people ultimately attended the meeting. A key component of recruitment was to ensure that the focused discussion included residents from or stakeholders representing the interests of low income, minority, vulnerable, or medically underserved communities.

[11] Lipmanowicz, H., & McCandless, K. (2010). Liberating structures: innovating by including and unleashing everyone. *E&Y Performance*, *2*(4), 6-19.

THI staff facilitated the needs prioritization workshop and successfully identified a prioritized list of health needs. THI staff presented the initial analysis of all data, facilitated discussion about the validity of the results, and identified approximately 10 issue areas for focused discussion based on the indicators presented. The facilitation ensured open discussion among all participants and used group consensus before moving to the next stage of the workshop. After discussion of the issue areas, participants voted on their top priorities based on a three-vote cumulative voting method. Facilitators from THI consolidated individual participants' scores to generate an overall ranking and a ranking based on community votes only to identify any differences in prioritization between community stakeholders and those from CHRISTUS. No differences were found, and the prioritization committee reached consensus on the composite ranking before finalizing the priority health needs list.

SUMMARY OF ACTIVITY SINCE THE 2016 CHNA

In 2016 CTMFHS completed its most recent CHNA and developed a companion Implementation Plan for CTMFHS-led community health improvement for the 2017-2019 triennium.[12] The CTMFHS pursued actions to address six top health needs identified in the CHNA. The information below summarizes the expanded actions CTMFHS has pursued since that time for each of the targeted prioritized health needs.[13]

SIGNIFICANT NEEDS WITH HOSPITAL IMPLEMENTATION RESPONSIBILITY

Access to Primary Care

CTMFHS's principal strategy to meet the primary healthcare needs of low income, uninsured, and Medicaid populations was to provide support to a Federally Qualified Health Center (FQHC) operating in the report area. CTMFHS supports the FQHC's electronic health record system (EHR), leadership training, and board meeting space and food. The FQHC provides over 75,000 encounters on an annual basis and has expanded to five locations in three counties.

CTMFHS has also leveraged its relationship with school districts to address healthcare access among school-age children. CTMFHS maintains a strong program to provide access for physical exams in low income school districts for students without any costs. In addition, CTMFHS offers a job shadowing program for high school students, students in summer programs, college students, and other adults interested in pursuing a career in healthcare. Few organizations in the region provide these opportunities, which has the potential to ensure a pool of future health professionals and para professions in the region.

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[12] CHRISTUS Health. *Community Health and Needs Assessment and Implementation Plan*. June 2016. Available at: https://www.christushealth.org/-/media/files/chip/christus-tmf-tyler-chna--chip-2016.ashx?la=en

[13] Note: Whereas the 2017-2019 Improvement Plan was based on results from a 3-county area composed of Cherokee, Smith, and Wood Counties, this 2020-2022 CHNA captures information from these three and four additional counties.

Coordinated and Collaborative Care
The 2016-2019 CHNA identified the need for better coordination and collaboration to address the fragmented nature of the broader healthcare system. In response, CTMFHS works closely with other health related facilities to better meet the needs for services and providers. This includes support that has enabled facilities to remain open and expand services. CTMFHS's EHR facilitates greater coordination and collaboration by offering a portal for patients at both the FQHC (see above) and CTMFHS clinics. This enables a wider group of patients with chronic disease to be referred to chronic disease programs.

Chronic Disease, Prevention, and Unhealthy Lifestyles
CTMFHS refers individuals at risk or managing chronic disease to programs to help them adopt and maintain healthy behaviors. CTMFHS supports these programs by participating in community events and by providing education, research, financial support, in-kind leadership to the organizations offering the services.

Access to Specialty Care
To address the need for improved access to specialty care, CTMFHS targeted orthopedic services to low income students. CTMFHS encouraged providers to volunteer their time to be on site for services to schools. This includes offering free clinic services and testing on Saturday mornings to ensure students are evaluated by an appropriate health professional to determine injuries outside of an ED visit. This program reduces absenteeism and presenteeism in schools, saves money for families, and keeps students healthy.

Reducing Health Disparities
Activities in the third prioritized need, *Chronic Disease, Prevention, and Unhealthy Lifestyles*, are directed to the same populations that would be targeted to reduce health disparities. Most CTMFHS activities to reduce health disparities involve financial and other support to non-profit programs and leadership volunteer programs that focus on education and family supports.

Behavioral Health
CTMFHS became a founding member of the Smith County Behavioral Health Leadership Team. This new collaborative is working to identify ways to address behavioral health issues in a systematic way. CTMFHS provides support to this and other committees, boards, and community groups addressing behavioral health needs. CTMFHS also provides funding to several organizations that offer direct patient services for behavioral health.

KEY FINDINGS

County Name	Population (%)
Cherokee County, TX	52,240 (13.4%)
Delta County, TX	5,298(1.4%)
Franklin County, TX	10,767 (2.8%)
Hopkins County, TX	36,496 (9.4%)
Rains County, TX	11,762 (3.0%)
Smith County, TX	227,727 (58.6%)
Wood County, TX	44,314 (11.4%)
Report Area	388,604

Table 1. Report Area Population, by County

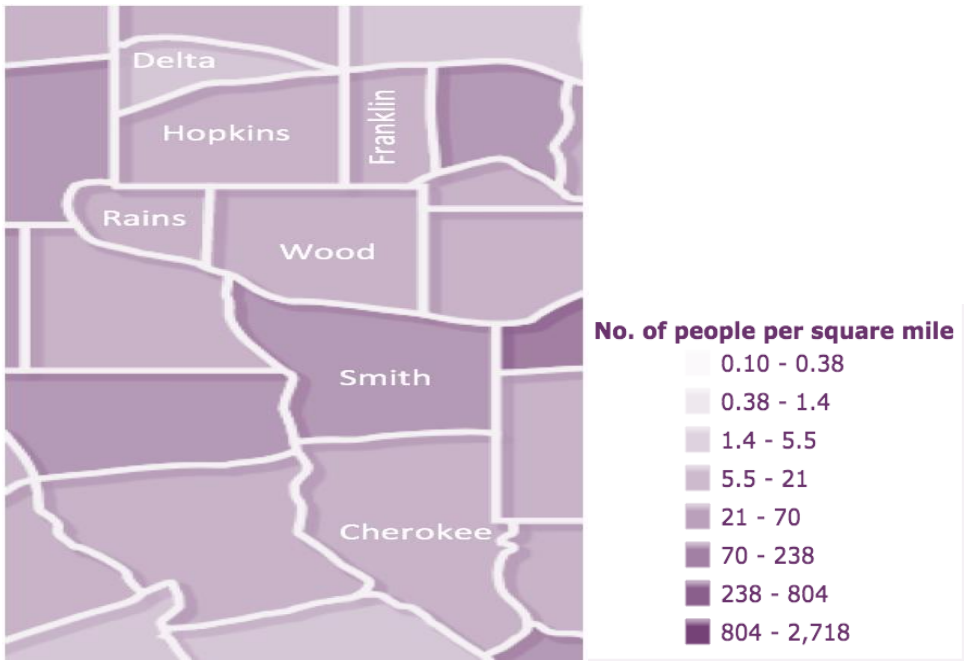

Figure 1. Report Area Population Density (Persons per Square Mile)

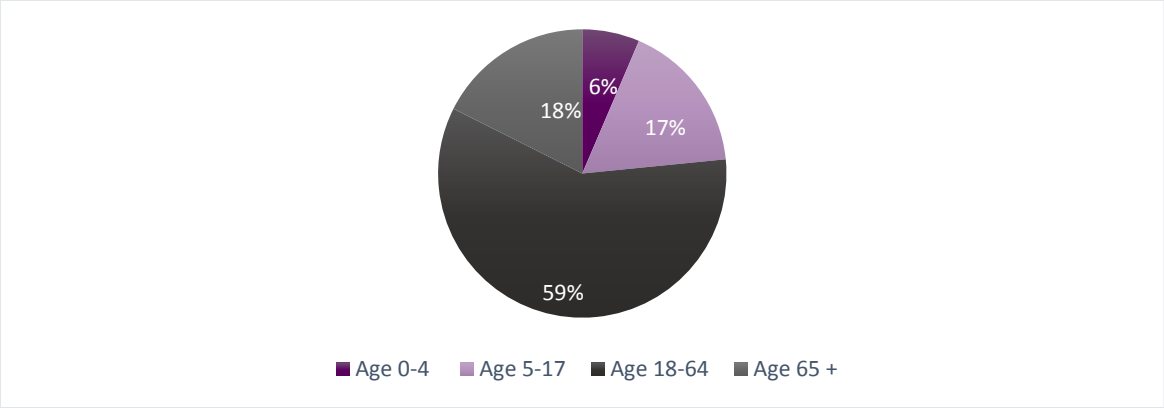

Figure 2. Report Area Population by Age Groups

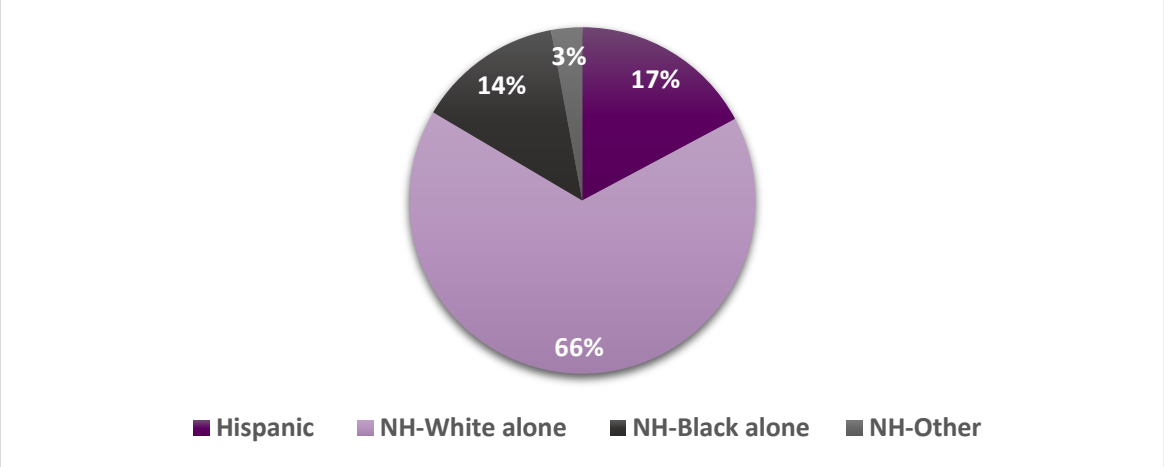

Figure 3- Report Area Population by Race and Ethnicity

Race and Ethnicity	Report Area	Texas	United States
Hispanic %	17.2	38.6	17.3
NH- White alone (%)	66.3	43.4	62.0
NH - Black alone (%)	13.6	11.6	12.3
NH- American Indian and Alaska Native alone (%)	0.4	0.2	0.7
NH - Asian alone (%)	1.1	4.3	5.2
NH - Native Hawaiian and Other Pacific Islander alone (%)	0.1	0.1	0.2
NH - Some other race alone (%)	0.1	0.1	0.2
NH - Two or more races (%)	1.3	1.6	2.3
NH -Other %	2.9	6.3	8.4

Table 2. Report Area Population by Race and Ethnicity

POPULATION DEMOGRAPHICS

To gauge the health needs of the very broad region CTMFHS serves, the report area includes the following seven counties: Cherokee, Delta, Franklin, Hopkins, Rains, Smith and Wood Counties. Consisting of a total population of 388,604 residents (Table 1), the report area (Figure 1) reflects the diversity communities in North East Texas from which CTMFHS patients could live while representing the bulk of individuals using CTMFHS services. Nearly 75% of the report area's population resides in Smith and Cherokee County. Fifty-nine percent of residents in the report area live in Smith County which is the only urban county, while the remaining 41% live in the remaining report area rural counties.[14] This also mirrors the urban-rural breakdown of Texas population statewide. The population increased in all counties within the report area having a population change of 6.6% from years 2010 to 2017.

Individuals between ages 18 and 64 (working-aged adults) constitute 59% of total population. Of the remaining population, 18% are ages 65 and older, 17% are school age children, and 6% are in infancy or early childhood (Figure 2). Overall, the population ages 65 and older are slightly higher than that of the population of Texas (12%). Rains (24%) and Wood (27%) Counties have an even higher population 65 and older. Compared to Texas, the population in the report area have a lower proportion of Hispanic residents (Table 2). The Hispanic/Latino proportion in the report area more closely resembles that of the US than that of Texas — just over 17% of the report area is Hispanic/Latino, compared to 39% of Texans. The NH-Asian, NH-Native Hawaiian/Pacific Islander and NH-Native American/Alaska Native categories each comprise less than 4% of the report area population. The report area population is almost evenly distributed by gender (49% male, 51% female), mirroring the gender distribution of Texas and the US.

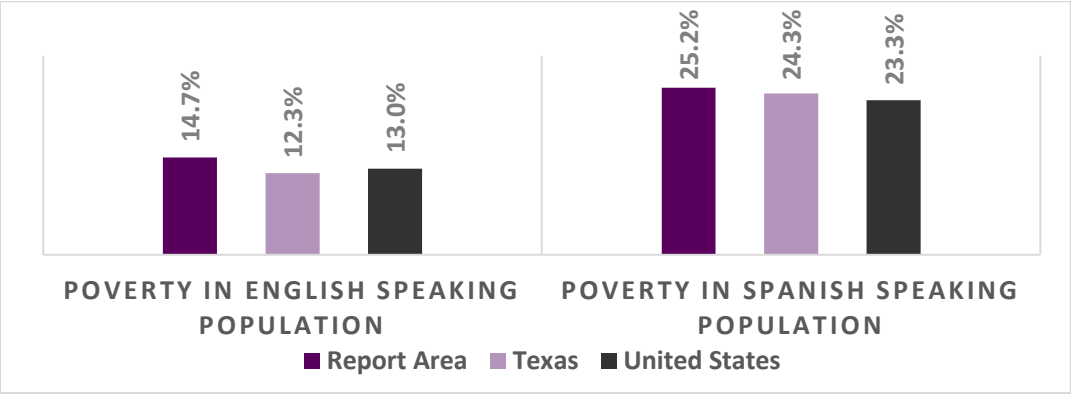

Figure 4. Poverty Distribution by Language

[14] Health Services and Resources Administration. (2016). List of Rural Counties and Designated Eligible Census Tracks in Metropolitan Counties. Available at https://www.hrsa.gov/sites/default/files/ruralhealth/resources/forhpeligibleareas.pdf

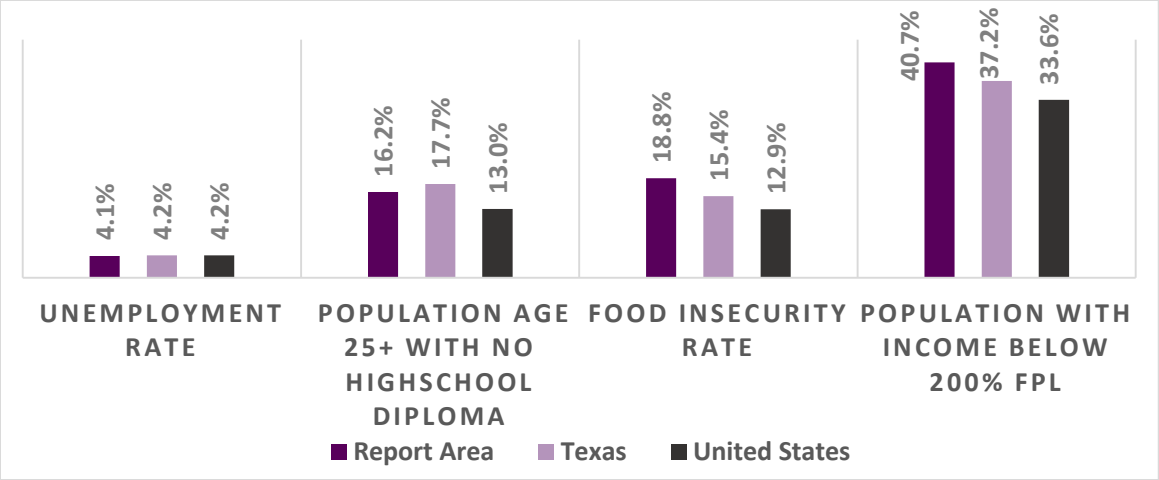

Figure 5. Socioeconomic Characteristics of Report Area

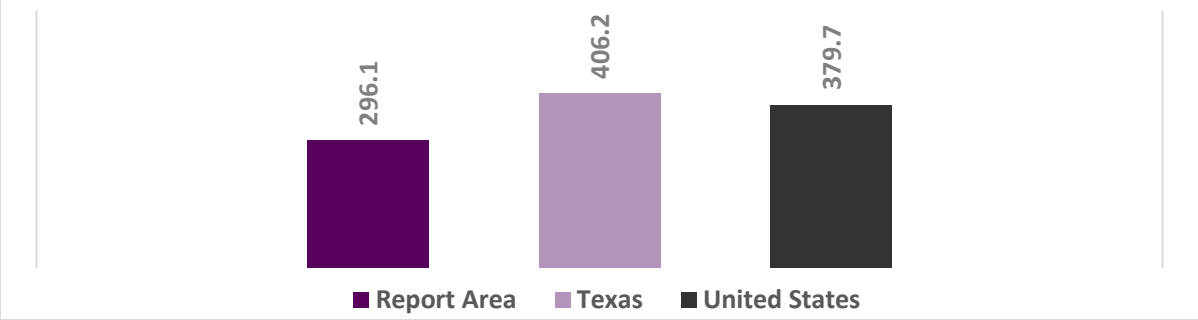

Figure 6. Violent Crime Rate per 100,000 Population

SOCIAL AND ECONOMIC ENVIRONMENT

Consolidated median income data for the report area is not available, but county-level data show that Smith County has a median annual family income just over $11,000 higher than Cherokee County ($60,719 compared to $49,680). For all counties, the income level is lower than Texas' median family income ($64,585).

Poverty is widespread in the report area, with 41% of report area residents earning annual incomes at or below 200% FPL. Cherokee County has even higher poverty at 49%. According to 2019 federal guidelines, 200% FPL corresponds to an income of $51,500 per year for a family of four.[15] Spanish-speaking populations have higher poverty rates than English-speaking

[15] Office of the Assistant Secretary for Planning and Evaluation. (2019). US Poverty Guidelines Used to Determine Financial Eligibility for Certain Government Programs. Available at https://aspe.hhs.gov/poverty-guidelines

populations for each county (Figure 4; Appendix A). The poverty within both populations mirrors the Texas and US poverty levels.

Figure 5 provides a comparative summary chart of socioeconomic indicators for the report area, Texas, and the US. High school graduation are on par with Texas. However, when broken down by county, Cherokee County has a higher percentage that have not completed high school (20%). Also, college graduation is slightly lower than Texas, 29% versus 35%, and varies widely by county with the lowest in Rains County at 17% and Smith County at 34%.

Compared to Texas, the report area's unemployment is similar while food insecurity is slightly higher (Figure 5). Nineteen percent of report area residents experience food insecurity (i.e., uncertainty about whether they will be able to get enough nutritious food at some point during the year) compared to about 15% of Texas residents. Overweight, obesity and chronic disease have remained consistent areas of need within the report area, and food insecurity can create barriers for individuals who need to manage their weight and nutrition. Feeding America measures food insecurity and defines it as a lack of consistent access to enough food for an active, healthy life.

Community safety represents an environmental indicator with implications for population health, including behavioral health. Violent crime (defined as homicide, rape, robbery, and aggravated assault) occurred in the report area at a rate of 296.1 violent crimes per 100,000 population, which is substantially lower than the overall violent crime rates in Texas (406.2 per 100,000 population) (Figure 6). Within the report area, substantial disparities in violent crime appear by county. Violent crime ranges from 69 violent crimes per 100,000 in Delta to 426.2 violent crimes per 100,000 in Cherokee County.

A common theme among the focus groups and key informant interviews was that many regions within the report area suffered from chronic poverty, limited affordable housing, and food insecurity. One participant noted that "Some of our schools are 100 percent free lunch because all of the students that are at those schools qualify." Another participant stated that "Poverty is a constant trauma" and this, in turn, drastically affects how one interacts with the healthcare system.

Walkability was noted as poor within communities and that there were limited options for transportation especially in the more rural areas (i.e. Trax, Go Bus, Hope Van). Sulphur Springs participants also stated poor water quality and drug and sex trafficking along I-30. Tyler and Sulphur Springs residents specified the need for a women and children's shelter as well.

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*Some of our schools are 100 percent free lunch—because **all** the students in those schools qualify.*

--Key Informant

ACCESS TO HEALTH CARE

Access to health care is a key component of maintaining and improving overall health. The Institute of Medicine identifies three essential steps in attaining access to care: gaining entry into the health care system, finding access to appropriate sites and types of care, and developing relationships with providers who meet patients' needs and whom patients can trust.[16] For many, health insurance represents not only a ticket into the health care system, but an assurance that the cost of most health services will remain affordable to them.

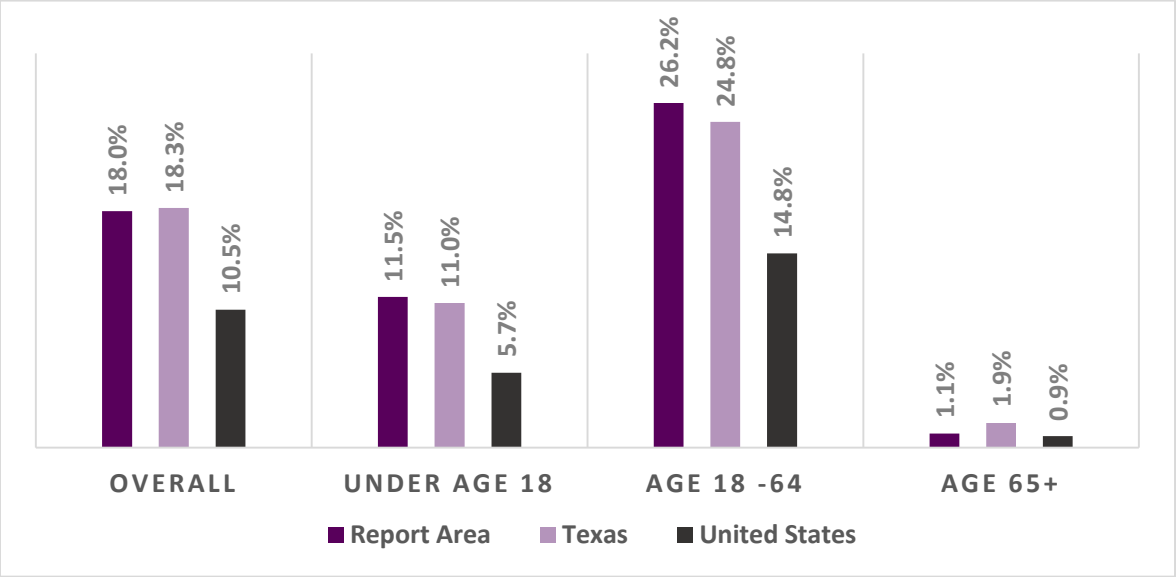

Figure 7. Uninsured Rate in Report Area, Overall and by Age Group

At 18% the rate of uninsured in the report area (18%) is the same as Texas' rate of uninsured. Less than 2% of elderly adults in the area are uninsured due to the availability of Medicare coverage for this age group (Figure 7). In contrast, 1 in 4 working-age adults in the report area are uninsured and approximately 1 in 10 children living in the report area are uninsured. At the time of this writing, Texas remains among the 14 states that have declined to expand Medicaid.[17]

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[16] Institute of Medicine. (1993). Access to health care in America. Committee on Monitoring Access to Personal Health Care Services. Washington, DC: National Academy Press.

[17] Kaiser Family Foundation. (2019). Stat of state action on the Medicaid expansion decision. Available at: https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Health insurance is just one component of access to care and does not guarantee access even to those who have it. Without an adequate supply of local health care providers, the health system will not have the capacity to accommodate all patients who need care, regardless of insurance status. Higher numbers of residents per provider in an area, the population to provider ratio, is an indicator of fewer providers available for the population in a region.

Differences in access to providers can be seen when comparing population to provider ratios across report area rural and urban counties. The only urban county, Smith, has provider ratios less than or close to those observed for Texas (Table 3). All the available county data from the rural counties show that most provider ratios are much higher than the report area and Texas. Note, however, that these ratios say nothing about the level of need for the services and many rural counties rely on nearby urban areas.

Geography	Primary Care Practitioners	Registered Nurse	General Dentists	Psychiatrist
Cherokee County, Texas	1,874:1	158:1	7,027:1	3,748:1
Delta County, Texas	--	237:1	5,677:1	--
Franklin County, Texas	3,862:1	386:1	3,862:1	--
Hopkins County, Texas	2,362:1	138:1	3,780:1	--
Rains County, Texas	--	576:1	6,339:1	--
Smith County, Texas	843:1	57:1	2,458:1	13,108:1
Wood County, Texas	1,820:1	248:1	5,257:1	--
Report Area	1,147:1	81:1	3,157:1	12,339:1
Texas	1,350:1	121:1	2,753:1	13,145:1

Table 3. Population to Healthcare Provider Ratio

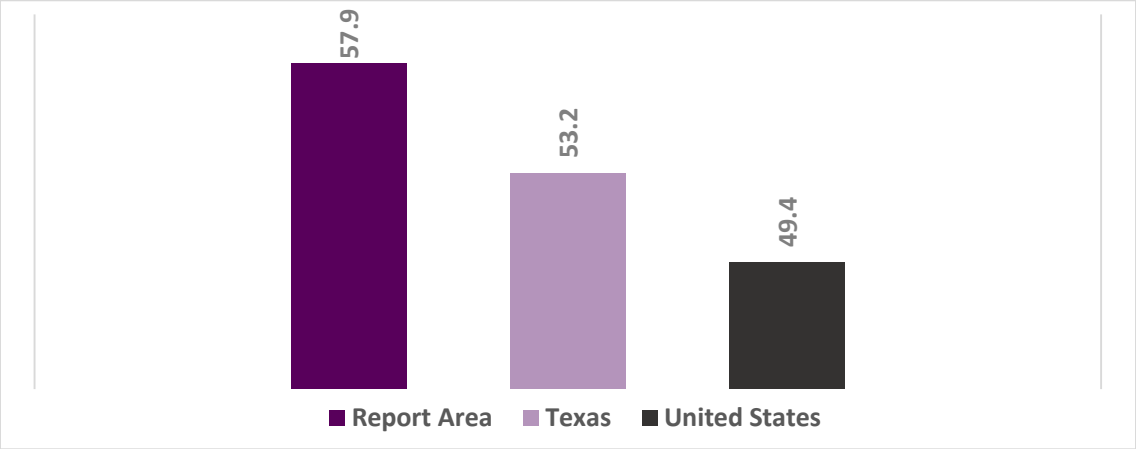

Figure 8. Preventable Hospital Admissions (per 1,000 Medicare Enrollees)

Primary care access barriers are a concern due to the potential for minor, treatable health conditions to worsen in severity, leading to avoidable hospital visits and potential overuse of costly emergency department services. Preventable hospital stays are defined as hospital visits for conditions that could have been prevented if adequate primary care resources were available and accessed by those patients. These preventable visits numbered 57.9 per 1,000 Medicare enrollees in the report area, not so different from the 53.2 preventable hospital events per 1,000 Medicare enrollees in Texas (Figure 8)**.**

In key informant and focus group interviews, stakeholders reported a lack of accessible care in rural areas like Jacksonville, Cherokee County and Sulphur Springs, Hopkins County. They also reported limited access to specialty care in endocrinology, orthopedics, endocrinology, orthopedic, gastroenterology, neurology, oncology, rheumatology and pediatrics. This theme was prevalent for Smith County as well, and it is common for individuals to travel to Dallas for specialty services due to long wait-times within the whole report area.

A wide range of informants hypothesized that consumers often lack the awareness, knowledge, or skills to navigate the system and use resources to their maximum benefit. Informants report the need for increased patient awareness about the economic consequences of using private free-standing emergency rooms, as they do not accept Medicaid, Medicare, or Tricare (military insurance). The lack of weekend hours among federally qualified health centers exacerbates this tendency to use emergency department services.

HEALTH OUTCOMES

Physical Health

All counties in the report area appear less healthy than Texas (Table 4). The number of days reported in poor health over the past 30 days ranges from 3.7 to 4.0 across counties in the report area compared to only 3.5 for Texas as a whole. Similarly, the prevalence of diabetes is higher for all counties in the services area compared to Texas. Whereas only 10% of individuals in Texas have (type 2) diabetes, the rate is 3.6 percentage points higher in Rains County, though less than a percentage point higher in Smith County.

Geography	Diabetes Prevalence (%)	Poor Physical Health Days
Cherokee County, TX	11.7	4.0
Delta County, TX	12.7	3.9
Franklin County, TX	11.8	3.7
Hopkins County, TX	11.7	3.9
Rains County, TX	13.6	3.4
Smith County, TX	10.8	3.7
Wood County, TX	12.3	3.7
Texas	10.0	3.5

Table 4. Diabetes Prevalence and Poor Physical Health in Report Area

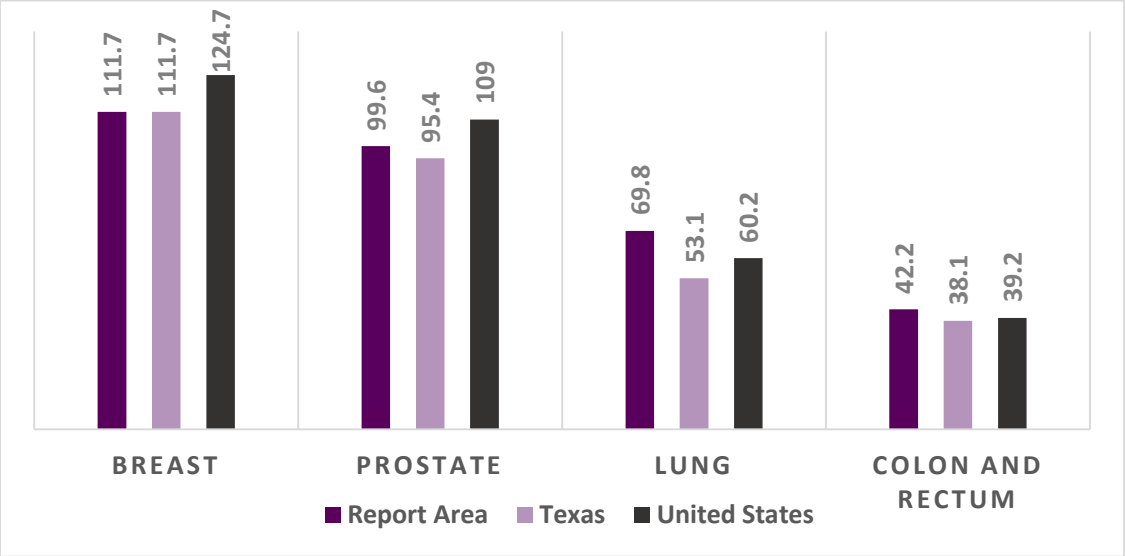

Figure 9. Age-adjusted Cancer Incidence per 100,000 Population, by Type

We're dying from chronic diseases. Chronic diseases cost about 80 percent of the healthcare budget.

--Key Informant

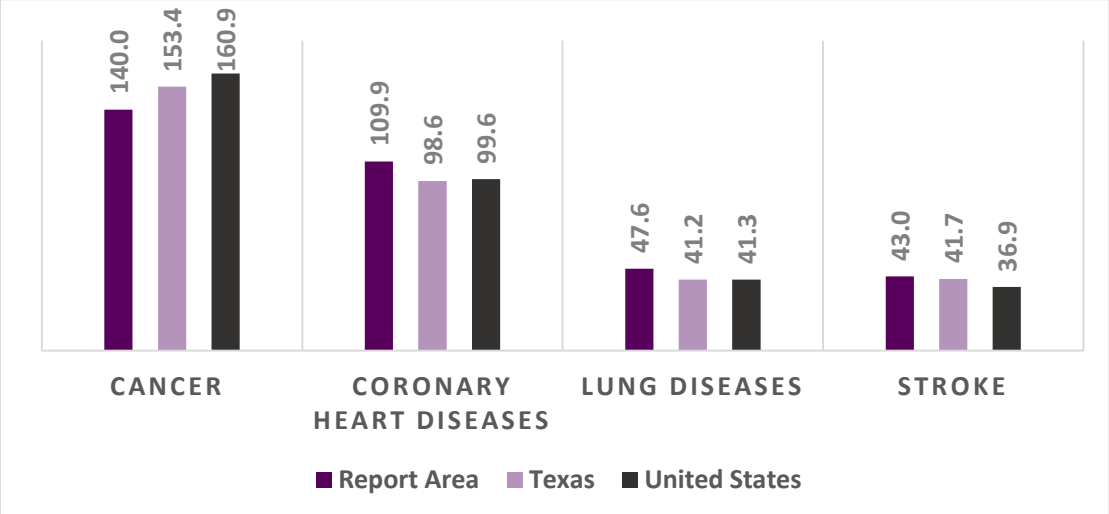

Figure 10. Age-adjusted Mortality Rate for Selective Diseases per 100,000 Population

Among all types of cancer, breast cancer has the highest incidence in the report area at 111.7 per 100,000. The incidence of breast and prostate cancers in the report area are on par with Texas and lower than the US rates (Figure 9). The largest differences observed are in the incidence of lung cancer. The lung cancer incidence rate at 69.8 per 100,000 is higher than both the Texas and US rate at 53.1 per 100,000 and 60.2 per 100,000, respectively. Although, compared to Texas and the US, cancer mortality is lower among residents in the report area. There are 13 fewer cancer deaths per 100,000 population in the report area than in Texas (Figure 10). Age-adjusted mortality from heart disease, lung disease and stroke causes are slightly elevated in the report area as well (Figure 10).

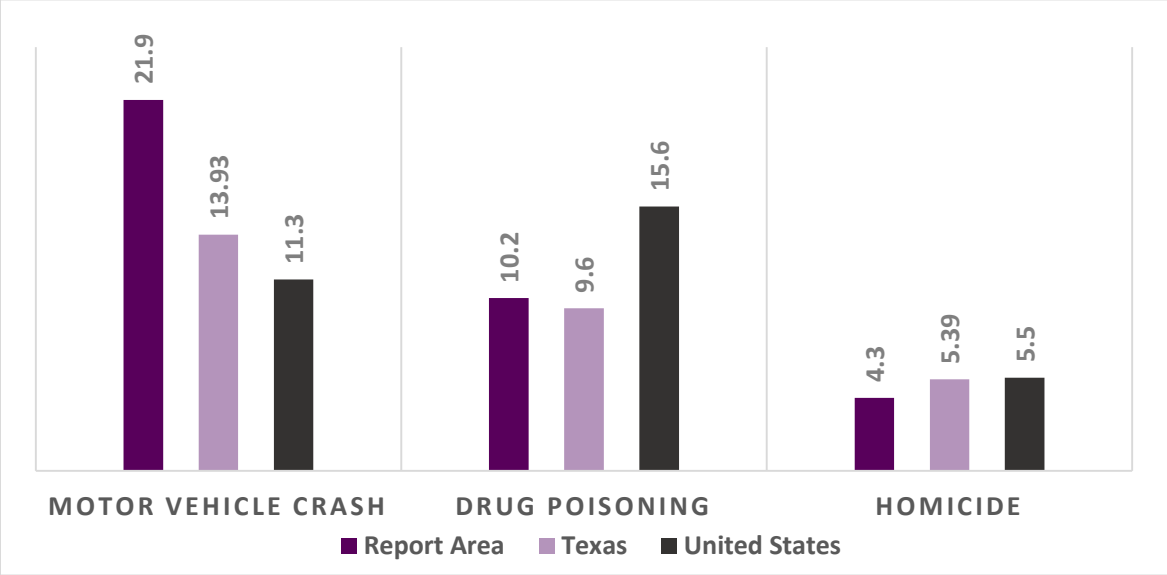

Figure 11. Age-adjusted Mortality Rate per 100,000 Population, by External Cause

Several mortality differences by external cause are notable. Motor vehicle crashes are significantly higher in the report area compared to Texas and the US. (Figure 11). The report area has a motor vehicle mortality rate of 21.9 per 100,000 compared to 13.9 for Texas and 11.3 for the US. This is even higher when broken down by county for Cherokee County at 28.6 per 100,000 and Wood County at 31.6 per 100,000.

Perhaps more than any other issue, stakeholders consistently noted the challenges associated with chronic disease. Diabetes, heart disease, hypertension, stroke, and cancer were raised numerous times throughout the key informant interviews and focus groups. Community members stressed the importance of educating the patient in regards to managing chronic illnesses and how to navigate the health care system. As well as increasing community collaboration and outreach in order to provide members of the community with this education.

Behavioral Health

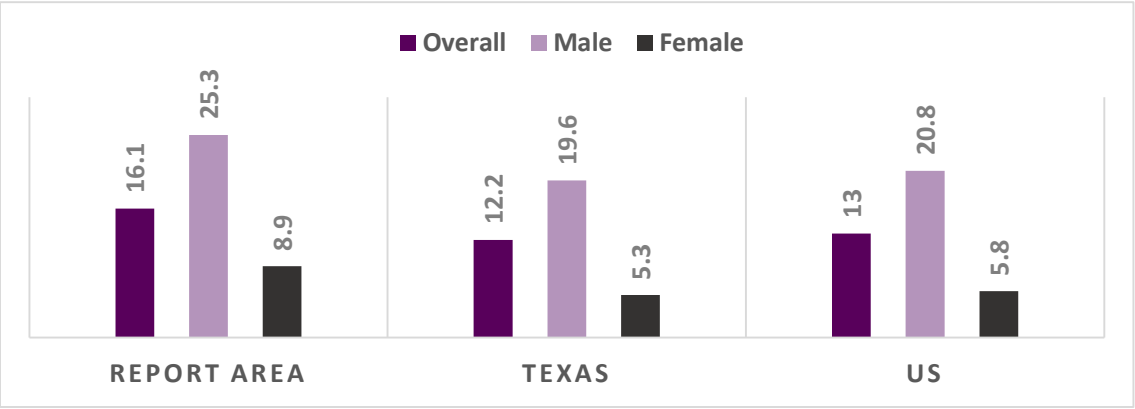

Figure 12. Age-adjusted Suicide Mortality Rate per 100,000 Population, Overall and by Gender

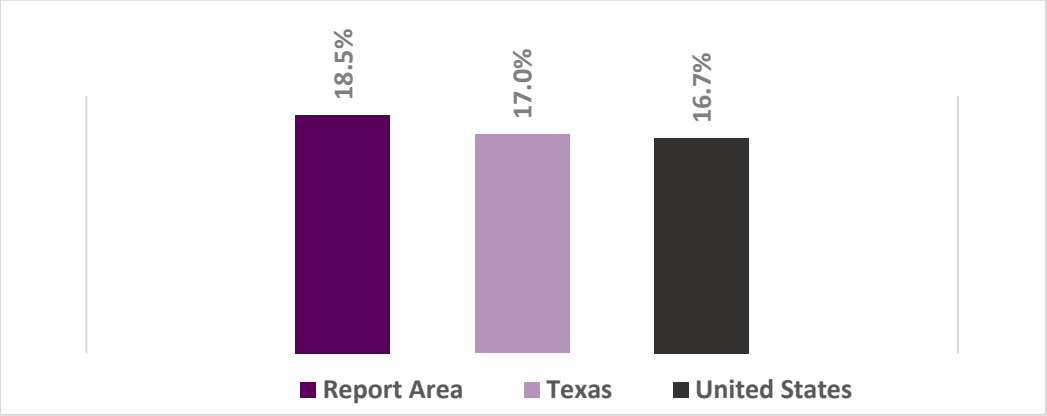

Figure 13. Prevalence of Depression among Medicare Beneficiaries

There is this concept of people not wanting to be identified as being less than or insufficient or not being as mentally well as they could be because they need help.

--Focus Group Participant

The burden of morbidity and mortality resulting from mental illness represents a significant and growing concern in the report area. After age adjustment, approximately 16.1 people per 100,000 population in the report area die of suicide, compared to 12.2 deaths by suicide per 100,000 population in Texas and 13.0 in the US (Figure 12). The suicide rate among report-area males (25.3 per 100,000) is significantly higher than the suicide rate overall, suggesting strong variation by gender. In the report area, males die by suicide at a rate approximately three times higher than that of females. Suicide risk is particularly elevated among older adults, which comprise a large and growing proportion of the report area population.

Depression, a major risk factor for suicide, affects 18.5% of Medicare beneficiaries in the report area, which is slightly higher than the rates of depression among Medicare beneficiaries in Texas and the US (Figure 13).

Behavioral health is considered the number one community health need. Stakeholders discussed at great length the lack of available inpatient and outpatient treatment options, long wait times. A significant barrier mentioned was that it is common for psychiatrists to provide services on a cash only basis and not accept insurance. It was also noted that the community has seen a rise in young children and the elderly struggling with mental illness.

Within the rural communities there is a recurring theme of drug abuse, particularly with meth and opioids. For the whole report area the most consistent topic that came up was the high rate of suicide that had a close connection to social isolation and stigma within the community.

MATERNAL AND CHILD HEALTH

Geography	Infant Mortality per 1,000 Live Births	Teen Birth per 1,000 Female Population Ages 15-19 Years	Low Birth Weight Percentage (< 2500 grams)
Cherokee County, TX	7	63	7.3%
Delta County, TX	NA	48	8.4%
Franklin County, TX	NA	37	8.0%
Hopkins County, TX	NA	48	7.4%
Rains County, TX	NA	32	5.7%
Smith County, TX	8	40	7.7%
Wood County, TX	7	37	6.3%
Texas	6	41	8.0%

Table 5. Maternal and Child Health

Healthy People 2020 stresses the role of maternal, infant, and child health as a key driver of overall population health and wellness. Delaying childbearing into adulthood decreases the likelihood of perinatal and postnatal complications, including infant mortality, low birth weight, and disability.[18] Over the long term, children born to teen parents are less likely to be prepared for kindergarten, have lower educational attainment and high school completion rates, and exhibit higher rates of social, emotional, and behavioral problems.[19]

Teen births by each county in the report area, defined as births to mothers age 15-19, are all on par with the Texas rate of teenage pregnancy except for Cherokee County (Table 5). Cherokee County has 63 teen births per 1,000 compared to Texas at 41 teen births per 1,000. Infant mortality rates are only available for the larger counties, but they are similar to Texas' infant mortality rate. This trend is seen well for the percentage of infants born with low birth weight in each county.

HEALTH BEHAVIORS

Geography	Adult Obesity	Physical Inactivity	Excessive Drinking	Adult Smoking	Insufficient Sleep
Cherokee County, TX	30.8%	33.5%	16.3%	17.5%	34.3%
Delta County, TX	29.1%	29.7%	17.0%	16.7%	30.8%
Franklin County, TX	28.6%	32.6%	17.4%	16.0%	30.5%
Hopkins County, TX	32.4%	30.8%	17.9%	16.8%	32.0%
Rains County, TX	30.9%	27.4%	18.6%	14.4%	29.2%
Smith County, TX	29.4%	29.7%	17.7%	16.5%	33.4%
Wood County, TX	29.4%	28.6%	17.6%	14.9%	29.3%
Texas	28.0%	24.0%	19.0%	14.0%	33.0%

Table 6. Health Behavior Indicators

Residents in the report area describe a wide variety of unhealthy behaviors as highly prevalent. Table 6 displays comparative prevalence rates of select health behaviors within the report area and Texas. Rates of obesity, physical inactivity, and tobacco use in the report area all slightly exceed those of Texas. The proportion of residents reporting heavy alcohol consumption (more than two drinks per day on average for men and more than one drink per day on average for women) or insufficient sleep was on par with Texas.

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[18] Healthy People 2020. (2014). Maternal, infant, and child health. Available at: http://www.healthypeople.gov/2020/topicsobjectives/topic/maternal-infant-and-child-health

[19] Youth.gov. (2016). Adverse effects of teen pregnancy. Available at: http://youth.gov/youth-topics/teen-pregnancyprevention/adverse-effects-teen-pregnancy

Of note, many of the counties in the report area have significantly higher prevalence of physical inactivity than Texas. For example, Cherokee County's prevalence of physical inactivity is 34% compared to Texas at 24%.

People should be empowered to know how many fruits and veggies they should be eating, how much activity they should be getting. You don't have to just exercise. Gardening counts. Walking pets counts as an activity. Walk and talk to your neighbors—versus signing up and going to the gym [only] to get burned out doing that. It's a mental paradigm shift

--Key Informant

HOSPITAL DATA

The CHRISTUS Trinity Mother Frances Health System supplied internal data from its main hospital and satellite hospitals to offer additional insight about community needs. These included two years of hospital admission and emergency department utilization data (2017-2018) disaggregated by facility, ZIP code, service line, and source of payment. For ZIP code, service line, and payment type, selected options reported at the greatest frequency and/or determined to be of interest are displayed to supplement understandings based on the primary and secondary community data.

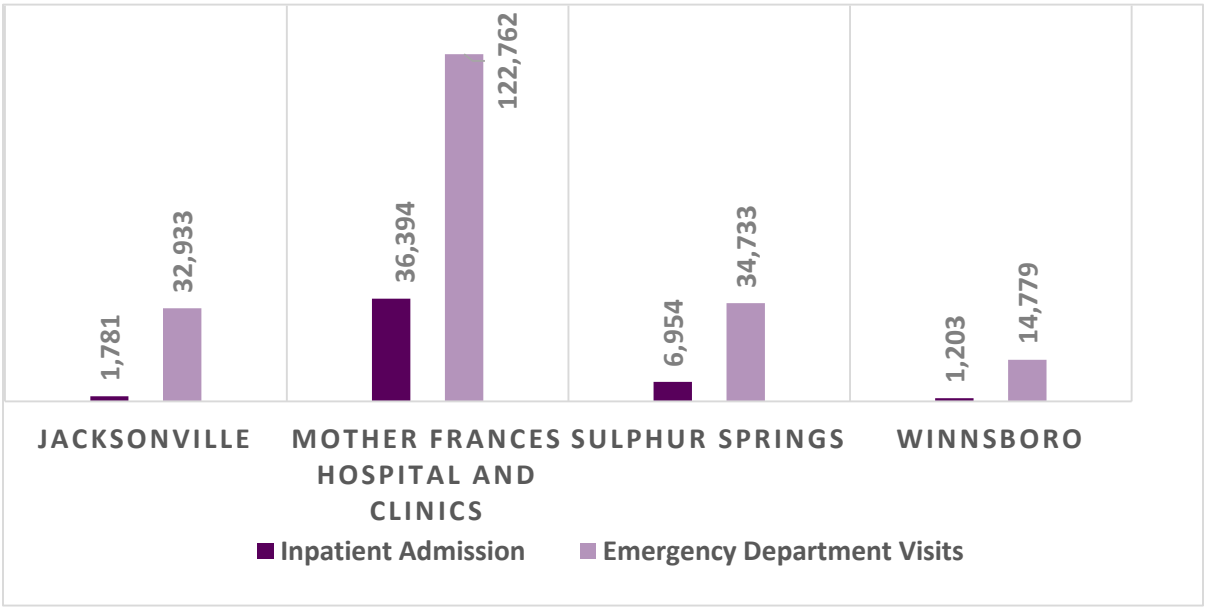

Figure 14. Total Inpatient Admissions and Emergency Department Visits by Facility (2017-2018)

Overall, the hospital data reveal a clear disproportionality in emergency department use compared to hospital admissions (Table 7; Figure 14). While some inherent differences may be expected, the frequency of emergency department visits overwhelmingly exceeded the frequency of hospital admissions over the data collection period. Emergency department visits exceeded hospital admissions and ranged from a ratio of 3.4 to 1 for the main CHRISTUS Trinity Mother Frances Hospital to as high as 18.5 to 1 for the Jacksonville branch.

While further analysis is needed to determine what may be driving utilization trends in the report area, disproportionate emergency department use can indicate a high number of patients cycling in and out of the emergency department. Such patterns may highlight concerns regarding overuse and/or misuse of emergency services within the report area. Data presented in Figure 8 show a relatively high rate of avoidable hospital events in the report area, further supporting the notion that use of the emergency department for non-emergent or preventable needs may be a system-wide concern. Individuals who make frequent visits to the emergency department are likely to have lower incomes, manage multiple chronic conditions, and report poorer health status — all important factors to consider when planning interventions for populations needing assistance managing their health in community settings.[20]

Facility	Inpatient Admissions			Emergency Department Visits		
	FY2017	FY2018	Total	FY2017	FY2018	Total
JACKSONVILLE	636	1,145	1,781	16,514	16,419	32,933
MOTHER FRANCES HOSPITAL AND CLINICS	17,899	18,495	36,394	57,397	65,365	122,762
SULPHUR SPRINGS	3,276	3,678	6,954	16,301	18,432	34,733
WINNSBORO	401	802	1,203	7,192	7,587	14,779

Table 7. Inpatient Admissions and Emergency Department Visits by Facility

[20] Peppe, E. Mays, JW, and Chang, HC (2007). Characteristics of frequent emergency department users. Kaiser Family Foundation, Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7696.pdf.

JACKSONVILLE		MOTHER FRANCES HOSPITAL AND CLINICS		SULPHUR SPRINGS		WINNSBORO	
ZIP Code	Number	ZIP Code	Number	ZIP Code	Number	ZIP Code	Number
75766	18,907	75702	20,691	75482	21,121	75494	7,491
75785	6,690	75703	17,069	75440	2,213	75783	1,232
75925	1,934	75701	16,629	75432	1,359	75457	967
75757	1,078	75771	7,416	75431	1,132	75497	706
75789	918	75707	6,427	75497	904	75482	561

Table 8. Top Five ZIP Codes for Emergency Department Visits

Table 8 highlights some variation in emergency department utilization by ZIP code. For the two-year period, nearly 50% of the CHRISTUS Trinity Mother Frances emergency department visits originate from three report ZIP codes, all clustered around the city center of Tyler: 75702 (North/ Central Tyler), 75703 (Southwest Tyler) and 75701 (South/Central Tyler).

For 2017-2018, the top zip code for each satellite branch encompasses over 50% of emergency department visits. For Sulphur Springs, this is even higher at 62% of patients from 75482 (Central Sulphur Springs). Of note, the Jacksonville and Sulphur Springs Hospital emergency department visits from zip codes 2-5 all represent patients from more rural regions that travel to access care. For Sulphur Springs this includes Emory (75440), Cooper (75432), Como (75431), and Yantis (75497). Jacksonville's rural regions comprise of Rusk (75785), Forest (75925), Mt. Selma (75757), and Troup (75789).

	Inpatient Admissions	
Rank	Service Line	Proportion
1	Obstetrics	14%
2	Neonatology	13%
3	Pulmonology	11%
4	Orthopedic Surgery	8%
5	Infectious Disease	7%

Table 9. Services Provided During Inpatient Admissions and Emergency Department Visit[21]

[21]Hospital data combine main and satellite branches.

General medicine represents the most frequent type of clinical service delivered both for patients admitted to the hospital and for those seeking care in the emergency department. Obstetrics is a service line unique to hospital inpatient admissions in these data as well as pulmonary medicine and orthopedic surgery (Table 9). Comparable data on emergency department visits by service line was unavailable.

Insurance Type	Inpatient Admissions	Emergency Department Visits
Private	22%	23%
Medicaid	17%	23%
Medicare	36%	22%
Medicare Replacement (MAP ADV)	13%	8%
Self-Pay	11%	20%
Other	1%	3%

Table 10. Payment Source for Inpatient Admissions and Emergency Department Visits[22]

Table 10 presents the proportion of patients paying with select payment types, including Medicare, Medicaid, Self-pay, MAP and Private. Not presented are data on patients enrolled in certain types of public insurance (e.g., CHIP, TRICARE). Clear differences in the payer mix between the admitted patient population and emergency care users are evident. Medicare pays for 36% of hospital admissions, but only 22% of emergency department visits. Conversely, the payer mix in the emergency department includes far more uninsured patients, who comprise 20% of the emergency department mix but just 11% of inpatient admissions. Also, the proportion of patients covered under Medicaid is slightly higher in ED visits compared to inpatient admissions (23% vs 17%).

OTHER FINDINGS

Behavioral health was identified as the top priority among the top five health needs in the community. In addition to the long wait times and lack of providers, there were many comments around the need for behavioral health education pertaining to available resources and what to do with residents' concerns about themselves, family members, or friends.

Many participants stated the growing needs of the elderly population within the community. This ranked as the fourth highest need within the community and encompassed many unique needs. Some of those needs arose from the loss of a primary care physician (PCP) after turning 65 as many PCPs do not accept Medicare patients. This is particularly troubling for elderly with needing psychiatric care. Medicare accepts Licensed Clinical Social Workers but not Licensed Professional Counselors, which limits available providers. Long waitlist for inpatient and outpatient behavioral health treatment further widens the gap between high health needs and available resources for both elderly and non-elderly residents.

[22] Data includes combined admission from main and satellite branches.

Informants offered some ideas about how to address these barriers. Many recommended greater collaboration and partnerships among major stakeholders. Appendix C contains a number of potential partners and stakeholders that could be involved in addressing the health needs uncovered in this report. Additionally, Sulphur Springs participants in Hopkins County stated a need for increasing specialist either through telemedicine or having a physician from a larger city come in once a week to treat patients.

Sensitivity Analysis

The analysis is based on data gathered within a report area that is meant to reflect the broad area CTMFHS serves. THI conducted additional analyses, not shown, to gauge the extent to which the selection of counties in the report area may have impacted the results. The sample excludes Anderson County, which has a sizeable African American population at 22%. No other county in the report area has such a high African American population. In addition, Anderson County is a designated rural county. Thus, it is possible that the health needs of African Americans, and potentially rural African Americans, were not adequately captured in this report. Nevertheless, the results of this CHNA appear consistent with other CHNAs conducted in the East Texas region. Many of the same health needs arose across counties throughout the East Texas region. For example, behavioral health was identified as a top need among all four East Texas regions for which THI conducted a CHNA.[23]

The analysis of hospital data does offer some information on the health needs of patients from Anderson as well as two other counties (Rusk and Van Zandt) that were not included in the report area. Tables for this analysis are in Appendix E. When all seven counties (included plus excluded) are ranked by the number of patients admitted to the hospital or the emergency department, the three excluded counties (Anderson, Rusk, and Van Zandt) are fifth, sixth and seventh in terms of the number of patients admitted to the hospital and in terms of the number of patients admitted to the emergency department. However, available data reveal few notable differences in the pattern of inpatient and emergency department use between included and excluded sample counties. Patients from the excluded counties in the report sample tended to utilize the CHRISTUS Mother Frances Tyler hospital—as do patients from the report counties.

Curiously, Medicare was more frequently the primary payer for inpatient and emergency department admissions for patients from the excluded counties compared to those in the report area counties. This is because the excluded counties have an older age distribution. As “primary care and elderly needs” was the fourth highest prioritized need (see Executive summary), this is yet another indication of the robustness of the sample used for the report area. More important, it suggests that this need might be especially pertinent for these other three counties.

[23] Texas Health Institute conducted concurrent CHNAs for four CHRISTUS health systems in East Texas covering 22 counties. Analysis of differences across the four service areas show strong similarities in health needs.

MOVING FORWARD

Findings from the qualitative and quantitative data and the final prioritization of needs highlight numerous gaps, issues, and threats to population health and quality of life in the communities comprising the report area. This CHNA report has also emphasized key resources, assets, capacity, and potential opportunities that exist in the region to address the identified problems. In particular, the voice of stakeholders in the community has been core and central to the needs assessment process, contextualizing data in community realities while shaping the process and product.

The content of this report is intended to inform planning and strategy for the CHRISTUS Trinity Mother Frances Health System in coming years. The findings from this CHNA report lay the groundwork for a companion Community Health Improvement Plan (CHIP) to aid the CHRISTUS Trinity Mother Frances Health System improve the health of the community it serves. The forthcoming CHIP will follow the release of this CHNA report and will describe opportunities, solutions, and innovations with the potential to address critical areas of unmet need in the region.

APPENDIX A: COUNTY LEVEL DATA

Indicator	Cherokee	Delta	Franklin	Hopkins	Rains	Smith	Wood
Age (%)							
Ages 0- 4	7.2	6.6	5.8	6.4	4.7	6.9	4.9
Ages 5-17	18.5	17.0	18.3	18.5	14.8	17.7	14.4
Ages 18 -64	57.0	55.9	54.6	57.1	56.2	59.1	53.6
Ages 65 +	17.3	20.5	21.3	18.0	24.4	16.2	27.1
Race and Ethnicity (%)							
Hispanic	22.1	6.7	13.7	16.0	8.4	18.6	9.4
NH- White alone	61.5	81.4	79.8	74.4	86.0	60.8	83.5
NH - Black alone	13.7	8.2	4.3	6.7	2.4	17.6	5.0
NH - Other	2.8	3.7	2.2	2.9	3.2	3.1	2.1
NH- American Indian and Alaska Native alone	0.1	0.2	0.7	0.3	0.9	0.3	0.7
NH - Asian alone	0.6	0.7	0.0	0.7	0.3	1.5	0.6
NH - Native Hawaiian and Other Pacific Islander alone	0.0	0.0	0.1	0.0	0.0	0.1	0.0
NH - Some other race alone	0.0	0.0	0.0	0.1	0.1	0.1	0.0
NH - Two or more races	2.0	2.7	1.4	1.7	1.9	1.0	0.8
Poverty (%)							
English Speaking Population	18.5	19.1	13.3	16.9	9.6	14.3	12.7
Spanish Speaking Population	29.2	20.8	30.5	30.8	20.1	24	15.3
Socioeconomic Characteristics (%)							
Unemployment Rate	4.5	3.4	4.3	3.7	3.7	3.9	4.6
Population Age 25+ with no Highschool Diploma	20.4	13.7	14.5	17.6	18.1	15.3	14.9
Food Insecurity Rate	19.2	20.4	18.0	18.2	16.0	19.2	17.3
Population with Income below 200% FPL	48.6	43.6	39.6	42.5	32.1	39.6	37.7
Violent Crimes (Per 100000 Population)							
	426.2	69.0	155.5	148.8	164.7	337.6	150.4
Uninsured Population (%)							
Overall	19.7	15.4	20.4	20.0	21.5	17.6	15.4
Under Ages 18	10.7	5.8	14.6	13.9	13.6	11.3	10.5
Ages 18-64	30.2	24.4	30.5	28.8	33.2	24.8	24.7
Ages 65 +	1.3	0.0	0.0	0.3	1.5	1.2	1.1
Preventable Hospital Admissions (Per 1000 Medicare Enrollees)							

Indicator	Cherokee	Delta	Franklin	Hopkins	Rains	Smith	Wood
	85.3	42.2	58.8	49.9	60.5	52.7	64.4
Cancer Incidence Rate (Age Adjusted Incidences per 100000 Population per Year)							
Breast	117.6	138.3	88.1	100.4	96.7	115	108.1
Prostate	35.8	-	52.7	45.4	41.5	42.4	42.8
Lung	86.8	60.7	58.7	70.6	80.7	64.8	72.7
Colon and Rectum	100.5	103.2	81	109.4	89.5	101.9	91.9
Mortality rates (Age Adjusted Deaths per 100000 Population per Year)							
Cancer	144	205.9	168.8	176.2	183.3	127.2	143.8
Coronary Heart Disease	113.6	181.6	147.3	151.7	108.4	96.8	119.8
Lung Disease	60.2	44.1	41.4	42.6	49.6	45.1	50.9
Stroke	54.6	51.4	40.3	53.1	67.8	37.5	42.2
Motor Vehicle Crash	9.3	-	-	-	-	9.7	13.5
Drug Poisoning	-	-	-	-	-	4.3	-
Homicide	28.6	-	-	24.7	-	18.1	31.6
Suicide	16.7	-	-	10.8	-	17	15.1
Depression in Medicare Population (%)							
Depression	19.7	17.3	16	16.7	18.1	18.9	18.3

APPENDIX B: KEY INFORMANT INTERVIEW PROTOCOL

[Notes to interviewer: All instructions to the interviewer are in square brackets. Do not read the statements aloud. Suggested script for interviewer appears in italics. The main questions are numbered. Interviewer should read and understand questions prior to starting the interview. Interviewer should cover all questions in protocol.

Questions phrasing is *suggested*. This is a discussion. Interviewer should phrase questions in a way that s/he is comfortable speaking.

Follow-up questions may be employed to more fully explore the topic area when applicable. If interviewer believes the concept has been covered s/he may skip follow-up questions. Probes are optional. If interviewer believes the participant has not fully engaged or answered the main or follow-up question s/he may use one or more of the "probes" to further investigate and engage the participant. These optional questions are listed below the main question stem.]

Hello, may I please speak with **[NAME]?**
My name is **[INTERVIEWER'S NAME]** and I am calling from the **[Texas Health Institute]. [INSERT CHRISTUS HEALTH CONTACT PERSON'S NAME]** from CHRISTUS Health gave me your information in order to participate in CHRISTUS Health's Community Health Needs Assessment. Thank you so much for offering to speak with me.

As you may know, all non-profit hospitals are required to conduct a community health needs assessment every three years. The purpose of this assessment is for the hospital to gain an

understanding of the current health status of their target area, learn about the top health needs and priorities, and to develop an action plan to address some of those health needs when possible. Part of the assessment is gathering quantitative data on health indicators from secondary analysis and the other part of the assessment process includes getting input from community residents and key stakeholders, which is why I am conducting this interview with you. Your input will be used to inform the health needs assessment and potential future action by CHRISTUS Health in your community. The interview will take a maximum of one hour.

In order to capture all of the information we talk about, I will be taking notes throughout the conversation. I will not record your name on the call; I will only start taking notes with the beginning of the questions. After the interview is completed, we will transcribe and code the interviews so that we can see if any themes arise across the multiple interviews conducted. All transcripts will be destroyed at the end of the project, and your responses will not be tied back to you in any way; the results of the interviews will only be reported in aggregate. Are you comfortable with having the conversation recorded in this way?

[IF YES]: Great, thank you. I will call you at **[DATE AND TIME].** I look forward to speaking with you then.
[IF NO, THANK THE PARTICIPANT FOR THEIR TIME AND END CALL]

[START HERE FOR ACTUAL INTERVIEW]

Hello, may I please speak with **[NAME]?**
Thank you so much for taking this time to speak with me. Do you have any questions about the assessment that we discussed during our last call? **[ALLOW TIME FOR QUESTIONS]**

[IF PREVIOUSLY AGREED TO RECORDING]: In order to capture all of the information we talk about, I am going to take detailed notes throughout our conversation. After the interview is completed, we will review and code the interviews so that we can see if any themes arise across the multiple interviews conducted. All of your responses will not be tied back to you in any way; the results of the interviews will only be reported in aggregate. Do you agree to participate in this way?

[IF YES, PROCEED WITH INTERVIEW]
[IF NO, THANK THE PARTICIPANT FOR THEIR TIME AND END CALL]

[BEGIN INTERVIEW]: Thank you! I appreciate your time. Again, please remember that your responses will not be tied back to you directly so feel free to be as honest as possible. We are truly interested in hearing your opinions and ideas. You may refuse to answer any question or topic during the interview. Do you have any questions? Let's get started. I am going to begin the recording now. **[BEGIN RECORDING]**

This is key informant interview **[#]** on **[day, date, time]**
As we go through these questions, please answer based on your perception for the following geographies: **[Insert Counties] —** counties

1. Can you please tell me a little bit about your background and how you are connected to CHRISTUS Health, if at all?

Probe: Are you a public health expert, local/county/state official; community resident; representative of CBO, faith-based organization, schools, other health setting, etc.?

Follow-up: Do you meet any of these criteria? [Note: Participant does not necessarily have to meet any of these to participate]
[CIRCLE ALL THAT APPLY]

1. Persons with special knowledge of or expertise in public health
2. Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
3. Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.

COMMUNITY HEALTH AND WELLNESS
2. What are some of your community's assets and strengths as related to the health and well-being of community residents?
Probe: primary and preventive health care; mental/behavioral health; social environment; any other community assets

3. What do you think are the physical health needs or concerns of your community? [free list]
Probe: heart disease, diabetes, cancer, asthma, STIs, HIV, etc.
Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?
Follow up: Are there organizations already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?
Follow up: These are the top 3 health needs we have identified: [Refer to data sheet and read the corresponding top 3 health needs for the region from which the interviewee is representing]. Do you think these are primary concerns for your community?

Follow up: Are there any other needs that should be addressed?

Follow up: Are there organizations already addressing these needs? [free list] If so, which ones?

4. What do you think are the behavioral/mental health needs or concerns of your community? [free list]

Probe: suicide, depression, anxiety, ADHD, etc.

Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?

5. What do you think are the environmental, including built environment, concerns facing your community? Not just limited to factors like air quality, these concerns can include things like access to green space, safe sidewalks or playgrounds, and reliable transportation. [free list]
Probe: Air quality, water quality, workplace related dangers, toxin/chemical exposures, transportation, green space, etc.

Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations, assets or infrastructure (i.e. green space, parks, bike lanes, etc.) already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?

6. Now I want you to think a little about a broader range of factors that could affect health. What do you think are the economic concerns facing your community? [free list]
Probe: Housing, employment, access to quality daycare, chronic poverty, etc.

Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?

7. Again, thinking about other issues that could impact a person's health and well-being, what do you think are the social concerns facing your community? These could be concerns that impact a person's ability to interact with others and thrive or concerns that influence how the members of that society are treated and behave toward each other.
Probe: Neighborhood safety, violence, dropout rates, teen and unplanned pregnancy etc.

Follow up: Who do these health needs or concerns affect the most (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

Follow up: Are there organizations, assets or initiatives in place already addressing these needs? [free list] If so, which ones? How could CHRISTUS possibly partner with or enhance the efforts of these organizations?

BEHAVIORAL RISK FACTORS
8. What are behaviors that promote health and wellness in your community?
Probe: Exercise, healthy nutrition, etc.

Follow up: Who engages in these positive behaviors and who is impacted (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?
Follow up: Based on your experience/ knowledge/ expertise, what could be done to facilitate that more individuals can engage in these behaviors?

9. What are behaviors that cause sickness and death in your community?
Probe: Smoking, drinking, drug use, poor diet/nutrition, lack of physical activity, lack of screening (breast cancer, diabetes, etc.), etc.

Follow up: Who engages in these risk factors and who is impacted (e.g. age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

HEALTH CARE UTILIZATION

10. Where do members of your community go to access existing primary health care?

Probe: Can you identify the facilities and what types they are (free clinic, private doctors office)?

Follow up: Who accesses these services?

Follow up: How often do they go to these facilities?

Follow up: What are the reasons they go (preventive, chronic care, etc.)?

11. Where do members of your community go to access existing specialty care?

Probe: Can you identify the facilities and what types they are (free clinic, private doctors office)?

Probe: What types of specialty care are people in your community seeking (ie gynecology, heart specialist, dialysis, etc.?

Follow up: Who accesses these services?

Follow up: How often do they go to these facilities?

Follow up: What are the reasons they go (preventive, chronic care, etc.)?

12. Where do members of your community go to access emergency rooms or urgent care centers?

Probe: Please identify these facilities:

Follow up: Who accesses these services?

Follow up: How often do they go to these facilities?

Follow up: What are the reasons they go (emergencies, preventive, chronic care, etc.)?

Follow up: Why do they go to emergency care facilities rather than primary care?

13. Where do members of your community go to access existing mental and behavioral health care?

Probe: Can you identify the facilities and what types they are (free clinic, private doctors office)?

Follow up: How often do they go to these facilities?

Follow up: What are the reasons they go (preventive, chronic care, etc.)?

ACCESS TO CARE

14. Are you satisfied with the current capacity of the health care system in your community?
Probe: Access, cost, availability, quality, options in health care, etc.

Follow up: Why or why not?
15. What are some barriers to accessing primary health care in your community? [free list]
Probe: inadequate transportation, long wait times, don't know where to go, lack of insurance, etc.

16. What are some barriers to accessing mental and behavioral care in your community [free list]
Probe: inadequate transportation, long wait times, don't know where to go, lack of insurance, stigma, etc.

17. Who are impacted by these barriers?
18. Reflecting on these barriers, what are one or two things CHRISTUS, its partners, or other organizations in the community could do to try to address these?

Those are all of the questions I have for you today. Is there anything else you would like to add before I turn of the recorder? **[ALLOW TIME FOR COMMENTS]**
Thank you very much for your time today; we really appreciate you sharing your thoughts on the current status and health needs of your community. If you have any questions about the interviews we are conducting, you can contact **[INSERT CONTACT NAME AND INFORMATION]**

Note: This interview was initially developed as a partnership between the Texas Health Institute and the Louisiana Public Health Institute. All prompts and probes are tailored to the informant.

APPENDIX C: COMMUNITY RESOURCES

An inventory of community resources was compiled based on key informant interviews, focus group discussions, and an internet-based review of health services in Tyler. The list below is not meant to be exhaustive but represents a broad sampling of feedback received from the stakeholder engagement process. The list of community resources is restricted to only those that are physically located within the report area. Several additional organizations located outside the report area may provide services to report area residents but fall outside the scope of inclusion in this needs assessment. Similarly, many of the organizations identified in this resource compilation serve a population broader than the report area but are included here in the context of the services they offer to report area residents.

Name	Description
Tyler	
2-1-1 East Texas	2-1-1 East Texas is a free, anonymous, information and referral service that is available to anyone, 7 days per week, 24 hours each day. The service helps to connect people with critical social services and charitable programs that are available in the local community. Simply dial 2-1-1 from any phone. Trained and certified Call Specialists assist every caller in assessing his/her need and providing referrals to available local charitable, nonprofit, and governmental agencies.
American Heart Association (Tyler, Jacksonville, Sulphur Springs)	We're building healthier lives where you live and work and making your community healthier by advocating for key health issues. We train millions of Americans each year in CPR and first aid, and educate healthcare providers every day. Find out more through our online tools, including Go Red For Women, Power to End Stroke, the Start! Program, our Youth Programs, and the Heart Hub, our online patient portal for information, tools and resources.
American Cancer Society (Tyler, Jacksonville, Sulphur Springs)	Your local American Cancer Society office is your source for the most relevant information to help guide you. Appointments are needed for all services to ensure we have the right people available to meet your needs. Hours and services vary by location. You can always call our Cancer Information Specialists at 1- 800- 227- 2345, 24 hours a day, every day of the year to connect with our valuable services and resources.

Name	Description
Andrews Center	The Andrew Center offers services for the following conditions, specialties and population groups: mental health, intellectual and developmental disabilities, medical management, consumer benefits, counseling, autism, children, at risk youth, adults, veterans, residential, jail diversion, transportation and vocational training. This location serves as the central point of contact for all Andrews Center business and administrative operations in addition to being an outpatient clinic.
Samaritan Counseling Center of Tyler	The Samaritan Counseling Center of Tyler adheres to the belief that there is a close relationship of mind, body, and spirit, and that optimal health care involves consideration of all three. The Clinical Staff are certified and/or state licensed in their professional disciplines. In addition to maintaining these clinical standards, the counselors will also be trained and supervised to help clients build upon their faith resources when appropriate. Clinical services are available to people of all faith traditions and to those who do not claim a religious identity. The Center is a non- profit and as such will be able to provide services to many in the community who would otherwise not be able to afford counseling.
Bethesda Clinic	Bethesda Health Clinic is a Christ - centered ministry with a bold mission: To provide affordable, high-quality care for the working uninsured and others we are able to serve. The clinic offers primary and specialty care, helps patients obtain long-term medications, ancillary services, dental services, and a healthy living program created to meet a need for monitored and ongoing diabetes care for uninsured diabetics.
Council Foundation for Life	Cancer Foundation for Life® (CFFL) is a 501(c)(3) non-profit organization founded in Tyler, Texas, in 2001, by retired oncologist Gary T. Kimmel, M.D. Soon after founding CFFL, Dr. Kimmel assembled a board of directors comprising well-established leaders from the medical and business community. He chose individuals who shared his vision of enhancing cancer treatment through the incorporation of a structured, long-term exercise program for all cancer patients, regardless of their level of disability. Oncologists, researchers, exercise

Name	Description
	academicians, and CFFL collaborate to achieve the Foundation's vision by incorporating FitSTEPS for Life® as a routine component of cancer treatment. The FitSTEPS for Life® program is an individualized, community- based program designed to improve the physical and mental functioning, quality of life, and survival of people living with cancer.
Catholic Charities of East Texas	Catholic Charities East Texas, incorporated in 2005, is a 501c3 non-profit agency dedicated to service, quality and outreach for members of the East Texas community, especially those who are poor, devalued and in need of help. The organization supports and provides the following initiatives and programs: Roses for Food Hunger Initiative, Community Gardening Program, Immigration Legal Services, Beat the Heat Initiative, and the Disaster Preparation Program.
East Texas Center for Independent Living	A non-profit agency providing services to the one in five East Texans who have disabilities. ETCIL assist people with: any and all types of disabilities such as: mobility impairments, amputations, spinal cord injuries, arthritis, multiple sclerosis, muscular dystrophy, post-polio, spina bifida, cerebral palsy, mental, cognitive, or developmental disabilities such as traumatic brain injuries, depression, learning differences, hearing loss and vision impairments.
East Texas Food Bank	The East Texas Food Bank cares about children, families and seniors who do not have enough food to eat. Every day we work to feed people through a variety of programs and services: BackPack Program, Kids Café/Snack Program, Summer Food Program, Senior Box Program, Senior Servings, Fresh Produce Program, Nutrition Education, SNAP/Food Stamps.
ETCOG Area Agency on Aging	The Area Agency on Aging of East Texas is designated by the Texas Department of Aging and Disability Services to coordinate services for persons in East Texas who are 60 or older, with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
Hospice of East Texas	The Hospice of East Texas provides in- home, hospital and long-term facility care to patients coping with terminal illness and the many challenges that are associated.

Name	Description
Lifeline	Lifeline is a personal emergency response system installed in your home so that you can enjoy your freedom and still feel secure that someone is there for you when you need them.
Literacy Council of Tyler	The mission of Literacy Council of Tyler is to improve the lives of individuals and their families by eliminating illiteracy through educational services. By providing these services to any adult in need, LCOT contributes to the quality of life in Tyler. Some of the accomplishments made by LCOT students are: learning to speak, read, and write English; completing a GED, participating in higher education or vocational training, influencing their children regarding the value of an education; obtaining or retaining a job, increasing the net income for their family, and many more.
Meals on Wheels, Inc.	Senior Citizens or disabled individuals may qualify to have five nutritionally balanced lunches delivered to their homes. All meals meet RDA requirements, are diabetic-friendly, and are prepared fresh daily. The daily meal delivery also allows the volunteer to perform a daily safety check on the well-being of the individual. When necessary, an emergency system is in place whereby help is summoned.
North East Texas Public Health District	The Northeast Texas Public Health District serves a vital function for the citizens of Smith County. The organization serves as the provider of health services, the protector of health, and the promoter of health care issues. We accomplish this function in several ways: laboratory services, public health preparedness, immunizations and tuberculosis elimination, community outreach and assistance and animal control.
Fit City Challenge	Fit City Challenge is a community- wide campaign to promote fitter lifestyles. The Tyler Morning Telegraph is spearheading the program with the help of community leaders. Dave Berry, editor of the Tyler Paper, describes the Fit City Challenge: “Through our reporting, we want to educate the community, providing information that highlights programs, tips and tools with which to fight. Through the Fit City Council, a group representing almost 40 medical, educational, governmental, business and charitable groups, we hope to inspire and

Name	Description
	challenge individuals, families, businesses and communities to take the first of many steps toward healthier lifestyles. If our reporting is good, if the council is able to expand fitness and health- related opportunities, and if more than a few people accept the challenge and adopt healthier lifestyles, then Tyler can truly be a healthier community — a 'fit city.'"
PATH (People Attempting to Help)	PATH is a faith- based social services agency addressing poverty in Smith County, Texas. The agency distributes fresh fruits and vegetables, assists in filing tax returns, hosts and education program and provides affordable housing for low income families in need.
St. Paul Children's Foundation	St. Paul Children's Foundation provides quality pediatric medical and dental care, operates a food pantry to provide assistance to children and their families in need, operates a clothes closet that provides new and gently used clothing and household goods at no cost, hosts a faith- based after school program, and provides a safe sanctuary for children to play at the Andrews Park.
Texas A&M Agrilife (All)	We provide research-based information in agriculture, horticulture, family and consumer science, 4- H and youth development and community resource development through educational programs. The Smith County Extension program is administered by a professional staff of Extension agents working with the Smith County Leadership Advisory Board. Educational programs are implemented through specific program area committees. Board and committee members are community volunteers interested in helping the people of Smith County.
Tyler Family Circle of Care	Through dedicated team members we will provide access to compassionate care for the whole family with unsurpassed quality. As a premier medical home of choice, we enhance the lives we serve and inspire hope, through comprehensive healthcare for years to come.
Alzheimer's Alliance of Smith County	The Alzheimer's Alliance of Smith County is a local, independent nonprofit organization committed to walking beside all those in Smith County on their journeys with Alzheimer's disease and dementia-related illnesses.

Name	Description
Tyler Type One	The Tyler Type One Diabetes Foundation was formed by family and friends of the Type 1 community in Tyler, TX in order to support one another in the daily challenges associated in living with Type 1 diabetes. Our mission is to provide vibrant local support for the Type 1 community whether they are children or adults.
Tyler Hispanic Business Alliance	The Tyler HBA provides many outstanding services, programs, and resources to the community. From business programs, training, consultations, student scholarships, to business and community signature events that allow our members to grow and develop within their professional and personal networks.
Your Philanthropy	Your Philanthropy is an independent firm focused on you and how you give. Individual, family, business or family foundation – you are the focus. ▪ Listens and helps you create a customized philanthropic plan to suit your specific needs. ▪ Joins your advisory team when invited – and works with you to achieve the highest comfort level and giving excellence. ▪ Believes in family and wants to help each person understand and appreciate their role in the family's giving plan. ▪ Comes alongside donors at any stage of giving, from formalizing a giving strategy and expanding a multi-generational giving plan to educating children about generosity or creating corporate giving programs for entrepreneurs and business owners.
East Texas Health Needs Network (All)	Diverse organizations and individuals working together for strengthened programs, connection and improved awareness of services that meet essential human needs.
East Texas Crisis Center	The East Texas Crisis Center is dedicated to providing safety, shelter, and education for victims of family violence, sexual assault, and other violent crime. Commitment to restoring dignity and purpose in the lives of victims and promoting public compassion and awareness in order to reduce violence in our community.

Name	Description
Home Health (All)	Adult and Pediatric Home Care that provides services that are designed to facilitate patient comfort and well-being. We treat all our patients like family, helping them maintain their health in the familiar setting of their own home.
Jacksonville	
HOPE (Helping Others Pursue Enrichment)	The mission of the H.O.P.E. organization is to provide emergency assistance to the indigent and to give them the tools and resources that promote self-sufficiency by pooling resources that provide assistance through a networking system designed to prevent duplication of services.
United Fund in Cherokee County	Started in 1975, the United Fund of Cherokee County has provided assistance to 19 different agencies in the Cherokee County area. Any donation you can give would be greatly appreciated. Please feel free to contact us if you have any questions about our organization.
ACCESS MHMR	Providing exceptional care and service to the members of the Anderson and Cherokee County communities.
Crisis Center of Anderson & Cherokee County	The aims and purposes of the Crisis Center of Anderson and Cherokee Counties are summarized as follows: • to provide a safe, temporary place in a homelike, supportive environment to enable the battering victim or non-offending family members of child victims to examine available choices for her/himself and any children the victim may have; • to educate the community, its agencies and citizens on the needs and experiences of battered and abused women, men and children and the problem of family violence in general; • to pursue long range goals to strengthen the family unit and to prevent and reduce the occurrence of violence within the family; • to provide counseling and other non-resident services for any victim of family violence, sexual assault or other victim of violent crime. • to coordinate services with all governmental and non-governmental

Name	Description
	providers in our service area to insure the provision of the best services to victims of domestic violence, sexual assault, and child abuse.
Cherokee County Public Health	Cherokee County Public Health exists to prevent disease, promote health, and protect all citizens, utilizing every available resource.
Sulphur Springs	
Cumby Food Pantry	Non-profit food pantry serving the residents of Sulphur Springs.
Glen Oaks	Glen Oaks Hospital is a 54-bed private mental health hospital in a relaxed setting in Greenville, Texas. Our comfortable, homelike atmosphere is conducive to healing for the adults and seniors we treat.
Lakes Regional MHMR	Lakes Regional Community Center will ensure access to services and support that enriches the lives of the individuals and families we serve, and we will be the first choice of citizens for mental health and Intellectual and Developmental Disability services.
Heart of Hope	Northeast Texas Heart of Hope (Heart of Hope), a Pregnancy Resource Center is a 501(c)3 non-profit organization located here in Sulphur Springs serving Hopkins County and the surrounding area. We are a FREE pregnancy resource center offering support to the mother and father.
Terrific Tuesday's	The local program provides a day of respite care for persons over age 50 with forms of memory loss. Terrific Tuesdays is held each Tuesday from 9am until 2pm at First United Methodist Church, downtown Sulphur Springs.
The Dinner Bell	The mission of the Dinner Bell is to end hunger in Hopkins County. Fresh, hot, nutritious meals are prepared by volunteers each Wednesday and served to our guests in the Fellowship Hall. Through the generous support of church and community members and corporate sponsors we have been able to serve over 20,000 meals to those in need since opening our kitchen in 2012.
CAN Help	What started out as a resource guide of available services in 2000 within Hopkins County, Hopkins County Community Action Network as we were originally known, has transformed into CANHelp — a non-profit organization, based in faith,

Name	Description
	whose mission is to provide assistance to individuals in the communities of Sulphur Springs and Hopkins County. CANHelp offers programs and training to those who want to become financially self-sufficient, various food and health items, and other basic needs to those experiencing crises, as well as information and referral services to those who call 2-1-1 Texas.
Christus Hopkins Health Alliance	Alliance with board members from CHRISTUS and Hopkins County Hospital District.
Hopkins Place Assisted Living	Hopkins Place, our senior living community, provides warm, homelike common areas just perfect for our residents to chat with each other in comfort and two beautiful courtyards for invigorating outdoor activities and gardening. We develop individual care plans to meet the needs of each resident, and a full-time registered nurse is available 24 hours a day to provide clinical oversight and coordination of care.

Note: Some services may be available in multiple counties.

APPENDIX D: HOSPITAL SENSITIVITY ANALYSIS

Table D1: IP admissions and ED visits by Counties, FY 2017-FY2018

	Inpatient Admissions			Emergency Department Visits		
	FY2017	FY2018	Total	FY2017	FY2018	Total
Report Area Counties						
All	22,212	24,121	46,333	97,404	107,803	205,207
Cherokee	2,203	2,718	4,921	16,641	16,967	33,608
Delta	180	238	418	799	890	1,689
Franklin	318	386	704	1,209	1,407	2,616
Hopkins	2,785	3,099	5,884	14,029	15,428	29,457
Rains	489	521	1,010	1,772	2,052	3,824
Smith	13,428	13,915	27,343	52,822	60,248	113,070
Wood	2,809	3,244	6,053	10,132	10,811	20,943
Other Key East Texas Counties						
All	4,262	4,264	8,526	10,889	11,277	22,166
Anderson	1,472	1,547	3,019	3,286	3,706	6,992
Rusk	763	737	1,500	1,923	1,915	3,838
Van Zandt	2,027	1,980	4,007	5,680	5,656	11,336

Table D2: Insurance Types by IP Admissions, FY2017-Fy2018

	Private	Medicaid	Medicare	Medicare Replacement	Self-Pay	Other
Report Area Counties						
All	22%	17%	36%	13%	11%	2%
Cherokee	20%	11%	38%	19%	11%	1%
Delta	19%	25%	35%	11%	7%	3%
Franklin	17%	13%	43%	17%	6%	3%
Hopkins	19%	19%	45%	7%	6%	3%
Rains	14%	17%	50%	11%	6%	1%
Smith	25%	18%	31%	12%	12%	2%
Wood	18%	14%	43%	15%	7%	3%
Other Key East Texas Counties						
ALL	23%	10%	41%	16%	9%	2%
Anderson	22%	9%	42%	16%	9%	2%
Rusk	29%	8%	37%	17%	7%	2%
Van Zandt	21%	12%	41%	16%	9%	1%

Table D3: Insurance Types by ED Visits, FY2017-2018

	Private	Medicaid	Medicare	Medicare Analysis	Self-Pay	Other
Report Area Counties						
All	23%	23%	22%	8%	20%	4%
Cherokee	23%	26%	17%	9%	23%	2%
Delta	24%	26%	20%	5%	19%	6%
Franklin	21%	19%	25%	11%	7%	17%
Hopkins	24%	23%	24%	4%	17%	8%
Rains	21%	19%	29%	8%	16%	6%
Smith	23%	23%	21%	9%	22%	2%
Wood	22%	17%	29%	11%	8%	13%
Other Key East Texas Counties						
ALL	25%	16%	27%	12%	18%	2%
Anderson	27%	16%	24%	10%	20%	2%
Rusk	28%	16%	25%	12%	16%	2%
Van Zandt	24%	15%	30%	13%	16%	2%

Table D4: Jacksonville Hospital: IP admissions and ED visits by Counties, FY 2017-FY2018

	Inpatient Admissions			Emergency Department Visits		
	FY2017	FY2018	Total	FY2017	FY2018	Total
Report Area Counties						
All	636	1,145	1,781	16,514	16,419	32,933
Cherokee	581	1,049	1,630	14,952	15,081	30,033
Delta	---	---	---	4	---	4
Franklin	---	---	---	4	---	4
Hopkins	---	1	1	1	6	7
Rains	---	---	---	4	---	4
Smith	55	93	148	1,543	1,328	2,871
Wood	---	2	2	6	4	10
Other Key East Texas Counties						
All	53	114	167	1,151	1,243	2,394
Anderson	43	102	145	955	1,060	2,015
Rusk	8	10	18	187	170	357
Van Zandt	2	2	4	9	13	22

Table D5: Mother Frances Tyler Hospital: IP admissions and ED visits by Counties, FY 2017-FY2018

	Inpatient Admissions			Emergency Department Visits		
	FY2017	FY2018	Total	FY2017	FY2018	Total
Report Area Counties						
All	17,899	18,495	36,394	57,397	65,365	122,762
Cherokee	1,622	1,669	3,291	1,683	1,879	3,562
Delta	25	29	54	20	12	32
Franklin	154	129	283	116	87	203
Hopkins	496	556	1,052	363	347	710
Rains	193	194	387	241	253	494
Smith	13,352	13,796	27,148	51,132	58,816	109,948
Wood	2,057	2,122	4,179	3,842	3,971	7,813
Other Key East Texas Counties						
All	4,127	4,059	8,186	9,479	9,795	19,274
Anderson	1,428	1,442	2,870	2,322	2,639	4,961
Rusk	754	722	1,476	1,726	1,734	3,460
Van Zandt	1,945	1,895	3,840	5,431	5,422	10,853

Table D6: Sulphur Springs Hospital: ***IP admissions and ED visits by Counties, FY 2017-FY2018***

	Inpatient Admissions			Emergency Department Visits		
	FY2017	FY2018	Total	FY2017	FY2018	Total
Report Area Counties						
All	3,276	3,678	6,954	16,301	18,432	34,733
Cherokee	---	---	---	4	5	9
Delta	155	209	364	767	870	1,637
Franklin	122	173	295	330	540	870
Hopkins	2,242	2,466	4,708	12,747	14,200	26,947
Rains	273	304	577	1,291	1,528	2,819
Smith	10	10	20	65	49	114
Wood	474	516	990	1,097	1,240	2,337
Other Key East Texas Counties						
All	79	76	155	210	210	420
Anderson	1	---	1	7	5	12
Rusk	---	---	---	4	8	12
Van Zandt	78	76	154	199	197	396

Table D7: Winnsboro Hospital: IP admissions and ED visits by Counties, FY 2017-FY2018

	Inpatient Admissions			Emergency Department Visits		
	FY2017	FY2018	Total	FY2017	FY2018	Total
Report Area Counties						
All	401	802	1,203	7,192	7,587	14,779
Cherokee	---	---	---	2	2	4
Delta	---	---	---	8	8	16
Franklin	42	84	126	759	780	1,539
Hopkins	47	76	123	918	875	1,793
Rains	23	23	46	236	271	507
Smith	11	16	27	82	55	137
Wood	278	603	881	5,187	5,596	10,783
Other Key East Texas Counties						
All	3	11	14	49	29	78
Anderson		3	3	2	2	4
Rusk	1	1	2	6	3	9
Van Zandt	2	7	9	41	24	65

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